WOMEN'S
REPRODUCTIVE
HEALTH

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WOMEN'S REPRODUCTIVE HEALTH

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BACKGROUND PAPER

WOMEN'S REPRODUCTIVE HEALTH, THE CANADIAN CHARTER OF RIGHTS AND FREEDOMS, AND THE CANADA HEALTH ACT

by Sheilah L. Martin
Faculty of Law
University of Calgary

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Executive Summary

A review of existing legal controls on women's reproduction uncovers a pattern of special regulation under which certain aspects of women's reproductive health care are treated differently from other medically necessary services. This complex web of legal and social controls includes federal laws on contraceptive devices and fertility drugs as well as birth-related criminal offences and federal powers which may be used to criminalize prenatal maternal conduct and abortion. Provincial and territorial governments also have wide powers to regulate local aspects of health matters. Existing laws establish rules concerning where and by whom abortions can be performed, impose tariffs which may operate as an economic disincentive for physicians performing needed medical services, authorize child welfare agencies to order the supervision and counselling of certain pregnant women, prohibit the practice of midwifery, and yet fail to regulate new reproductive technologies. Previous regulations have required third-party approval or counselling for abortions and have attempted to withdraw funding from sterilization, the insertion of intrauterine devices (IUDs), and abortion. Controls on women's reproductive health care are also imposed by health-care professionals.

Within this context, a major problem facing women in Canada is the timely availability of publicly funded reproductive health-care services. The *Canada Health Act*, which operates as a conditional federal grant in aid to the provinces, requires that their health plans meet the criteria of comprehensiveness, accessibility, universality, portability, and public administration before they merit full federal contribution. These criteria are integral to the national vision of a comprehensive health-service system which is both accessible on uniform terms and conditions and available regardless of one's ability to pay. In some cases, provinces have used their jurisdiction over health in a manner which may be inconsistent with the criteria of the *Canada Health Act*. Medically necessary services may not be provided or may be provided only on special terms and conditions; public funding may be withheld, tightly controlled, or set at unrealistically low rates. The legality of such provisions may be questioned in many different ways.

For example, an offending decision may be impugned directly under:

- an administrative law claim that the government did not have the authority to enact the regulation;
- an administrative law claim that the regulation offends the criteria in the *Canada Health Act*; and/or
- a Charter challenge that the regulation or government action infringes women's constitutionally protected rights.

The legality of full federal payment, when only partial services are supplied, may also be challenged. Thus, a number of arguments can be raised against the federal government to promote compliance with the criteria of the *Canada Health Act*.

A Charter-based challenge to inappropriate government action widens the scope of judicial review and increases the range and efficacy of available remedies. A Charter action is a powerful tool to effect social change and stimulate public

awareness. It provides individual complainants with a direct means to challenge government action and it often forces the government to publicly account for and explain its actions. The *Charter of Rights and Freedoms* is an instrument intended by its framers to relieve against disadvantage (under a purposive approach to sections 7, 15 and 28, where rights are interpreted according to the interests they were intended to protect). As a result, women are entitled to the full amplitude of life, liberty, security of the person, and of equality. Women's ability to bear children should create no exceptions from these rights and no burdens upon them; indeed, the Charter should be used to create the social and legal requirements for their full realization. The Charter, therefore, is an important instrument which should be used to overcome the historical and systemic discrimination against women, address women's material inequality, and accommodate their biological capacities.

In defining the content of Charter rights, the criteria of the *Canada Health Act* may be invoked to determine which legal rights to health care currently exist and to establish our national commitment to publicly funded quality health care for all persons. The criteria of the *Canada Health Act* may be incorporated into a Charter analysis because they represent the minimum standard of health-care benefits voluntarily assumed and recognized by both the federal and provincial/territorial governments. Therefore, the criteria of universality, accessibility, and comprehensiveness may be used to help define the content of women's Charter rights in the health-care context. Because the Act evidences the government's self-imposed health-care obligations, there is little concern of creating constitutional rights to health care from whole cloth or imposing new and positive obligations on either level of government. The courts would merely be asked to acknowledge and enforce bargained-for undertakings according to agreed-upon terms.

When articulating arguments concerning women's Charter rights to reproductive health care, it is important to present a sex equality analysis and to speak in terms of reproductive control and not merely reproductive choice. This dual emphasis requires decision-makers to take into account the real life conditions of women in Canada as a group and within a modern context and reinforces that women require actual services and not merely notional rights. Only in this way will decision-makers, including governments, health-care professionals and judges, begin to recognize and to truly understand that women's childbearing capacities create distinct medical needs which must be met if all persons in Canada are to have reasonable access to comprehensive, accessible, and publicly funded health-care services.

Introduction

Women have distinctive health-care needs because of their biological role in human reproduction. Statistics Canada reports that 70 per cent of the hospitalization of women between the ages of twenty and forty-four is attributable to their childbearing capacities and diseases affecting their reproductive organs.[1] Women also visit doctors in greater numbers and more frequently than men in the 15 to 64 age group because of their reproductive health needs.[2] The ability of women to bear children means that medical services concerning contraception, sterilization, pregnancy, abortion, childbirth, surgery, infertility, breast examinations, premenstrual syndrome, and menopause have become recognized aspects of women's reproductive health care. Unfair restrictions on necessary reproductive health-care services undermine the nationally recognized goal of accessible quality health care for all persons and jeopardize the physical and psychological well-being of women in Canada.

Improper barriers may be removed by litigation, lobbying, and education. Each of these strategies requires an understanding of the legal obligations of health-care regulators and the rights of women under the *Canada Health Act*[3] and the *Canadian Charter of Rights and Freedoms*.[4] The *Canada Health Act* outlines the criteria under which health-care services are available and administered; the Charter establishes the rights and freedoms enjoyed in Canada. This paper will analyse the extent to which these laws outline or support a right to health care responsive to the childbearing capacities of women.

Impediments to women's equal and adequate reproductive health care may arise at any of the numerous levels at which women's reproductive health care is regulated. For example, the federal government, provincial and territorial governments, professional medical associations, hospital boards, and individual health-care professionals all control the availability of medical services essential to women's reproductive health. This control can take the form of statutes, regulations, executive decisions, the allocation of public funds, policy decisions, bureaucratic requirements, administrative pronouncements, and decisions relating to medical treatment. The existence and extent of women's rights to health care under the *Canada Health Act* and the Charter therefore must be seen in the larger context of these pervasive legal controls over women's reproduction.

In addition, women's place in Canadian society and the traditional response of the legal system to women's biological capacities must also be acknowledged. When a court questions whether an impugned regulation infringes an interest protected under the *Canada Health Act* or the Charter, it considers the social context in which the impugned regulation operates and measures its effect on the protected interest. The Supreme Court of Canada has recognized that decisions involving Charter rights may involve

> . . . a determination which is not to be made only in the context of the law which is subject to challenge but rather in the context of the place of the group in the entire social, political and legal fabric of our society.[5]

Accordingly, women's vast social and material inequality, the political marginalization of "women's issues", and special laws regulating women's conduct are all relevant considerations when assessing whether a particular form of regulation jeopardizes women's reproductive health-care rights under the *Canada Health Act* and the Charter.[6]

In addition, one must recognize that traditionally courts have had difficulty integrating women's unique childbearing capabilities into a legal theory of rights. As Justice Wilson explained in the *Morgentaler* decision:

> . . . the history of the struggle for human rights from the eighteenth century on has been the history of men struggling to assert their dignity and common humanity against an overbearing state apparatus. The more recent struggle for women's rights has been a struggle to eliminate discrimination, to achieve a place for women in a man's world, to develop a set of legislative reforms in order to place women in the same position as men . . . It has not been a struggle to define the rights of women in relation to their special place in the societal structure and in relation to the biological distinction between the two sexes. Thus, women's needs and aspirations are only now being translated into protected rights.[7]

Translating women's needs into protected legal rights challenges the courts to interpret legal protections in a gender-inclusive manner and to acknowledge and incorporate women's specific reproductive capacities, their life experience, and their struggles to eliminate inequality.

The Sources and Forms of Regulation Concerning Women's Reproductive Health

A complex network of regulation governs women's reproductive health in Canada. Many different decision-makers are involved and each employs a variety of regulatory methods. In this section of the paper, the jurisdiction of the federal, provincial, and territorial governments as well as the role of health-care professionals will be outlined to illustrate the manner and extent of legal controls on reproductive health. The source and form of decisions concerning women's reproductive health care are also important because, as will be discussed in a subsequent section, only those decisions which qualify as "state action" must comply with the Charter.

The Federal Government

The federal government's jurisdiction over certain aspects of women's reproductive health is based on its interest in national health and welfare, its criminal law power, and its spending power. The constitutional limits on federal and provincial legislative powers are found in the *Constitution Act, 1867*.[8] Both levels

of government may legislate in respect of women's reproductive health because "health" is "not a single matter assigned by the Constitution exclusively to one level of government."[9] Health has been called an "amorphous topic" which can be addressed by valid federal or provincial and territorial legislation, depending on the circumstances and the nature or scope of the health problem at issue. In *Schneider v. The Queen*, Justice Estey explained:

> Health is not a subject specifically dealt with in the *Constitution Act* either in 1867 or by way of subsequent amendment. It is by the Constitution not assigned either to the federal or provincial legislative authority. Legislation dealing with health matters has been found within the provincial power where the approach in the legislation is to an aspect of health, local in nature . . . On the other hand, federal legislation in relation to "health" can be supported where the dimension of the problem is national rather than local in nature . . ., or where the health concern arises in the context of a public wrong and the response is a criminal prohibition.[10]

Parliament's jurisdiction over health matters of national dimension is supported by its power to legislate for the peace, order, and good government of Canada. Even though the national dimensions aspect of this power has been given a fairly circumscribed scope, certain health matters of national concern — for example, some of the regulatory health aspects of abortion — may be within federal control.[11] Parliament relies on these powers and its criminal law power to support the *Food and Drug Act*[12] which has a direct impact upon women's reproductive health. Under it, the federal government evaluates and/or approves all drugs or devices before they can be made available in Canada, including those concerning contraception, pregnancy termination, and infertility.[13]

The federal government also has the power to define crime and determine punishment. The criminal law power is invoked to sanction the type of conduct so detrimental to society's social and moral fabric that criminal prohibitions and penalties are warranted. What triggers this level of societal disapprobation may change. For example, until 1969 the sale and distribution of information concerning contraceptive devices was prohibited by the *Criminal Code*.[14] More recently, the criminal law power was used to create abortion-related offences. Non-therapeutic abortions were prohibited under section 251 of the *Criminal Code*.[15] In January 1988, this provision was invalidated by the Supreme Court of Canada in the *Morgentaler* decision because it improperly infringed women's Charter rights.[16] The Court confirmed that a criminal law on abortion could be a valid federal enactment, leaving Parliament with the option, but not the obligation, of recriminalizing the abortion operation in a manner consistent with women's Charter rights.

Other abortion- and birth-related criminal provisions remain.[17] Parliament's criminal law power currently supports section 252 of the *Criminal Code*.[18] This section prohibits the supply of a "drug or other noxious thing" knowing it is intended to be used to procure a miscarriage. Curiously, this offence can be committed whether or not the woman is pregnant. This prohibition may take on a new significance in light of the current research on, and impending availability of, oral abortifacients.

Controversy can also be anticipated over whether the federal government should introduce a criminal law to explicitly punish pregnant women for negligent or reckless conduct that harms or may harm their fetuses. Such conduct has been called "prenatal abuse".[19] In 1989, the Law Reform Commission of Canada proposed a new prohibition, under the heading of "Crimes Against the Foetus", which appears wide enough to criminalize certain prenatal maternal conduct.[20] While no U.S. state has explicitly criminalized prenatal fetal abuse, general criminal law prohibitions have been used in an attempt to reach a similar result. For example, charges were laid against a pregnant woman under a *California Penal Code* provision similar in principle and wording to section 197 of Canada's *Criminal Code*.[21] Both provisions require that a parent provide necessaries of life for a "child". The California Municipal Court dismissed the charge because an unborn fetus was not within the statute's definition of a "child". Using similar reasoning, Canadian courts have also held that an unborn fetus is not a "person" as that term is used in the *Criminal Code*[22] and is not a "child" for the purposes of provincial child welfare legislation.[23] These Canadian cases suggest that our courts will not allow any indirect attempt to use general criminal law provisions to criminalize maternal prenatal conduct. However, the issue of whether a pregnant woman's conduct during pregnancy should be defined, enacted, and enforced as a crime against the fetus is expected to be the subject of vociferous debate in Canada.[24]

The federal government may also rely upon its spending power to indirectly forge a national health-care policy. The federal spending power is not expressly enumerated as a separate head of power in the *Constitution Act, 1867* but its source is Parliament's ability to levy taxes, regulate public property, and appropriate federal funds.[25] The federal government can spend money on matters, such as some aspects of health care, outside its legislative jurisdiction. One example is the federal/provincial cost-sharing program at the base of our present system of publicly funded health-care services.[26] Therefore, the federal financial contributions to provincial health programs and the *Canada Health Act* are federal initiatives important to women's reproductive health; they will be explained more fully in a subsequent section.

The Provincial and Territorial Governments

The *Constitution Act, 1867* gives each province the jurisdiction to regulate matters of public health of a local nature within its boundaries. Provinces and territories control property and civil rights within the province/territory and have express authority over the establishment, maintenance, and management of hospitals.[27] Because of the scope of these powers, provinces/territories can affect women's access to medically necessary reproductive health services in many ways. A current example of the impact of provincial/territorial powers and local preferences is the regulation of abortion as a health issue since the Supreme Court invalidated the *Criminal Code* provision.

It should be remembered that provincial/territorial regulatory power over the medical aspects of abortion is not new. Even when section 251 governed the criminal law on abortion, the provinces/territories controlled the availability of abortions under the therapeutic abortion committee process, either through direct regulation or indirectly through delegation to the hospital committees. An attempt at direct regulation occurred when the Saskatchewan government proposed legislation which would have made it an offence to perform, cause, or approve an abortion without the written consent of the woman's husband, or parents or guardian if she was unmarried and a minor. In a reference case to determine the constitutionality of the proposed law, the Saskatchewan Court of Appeal decided that the province could not impose such requirements because to do so would improperly invade Parliament's jurisdiction over criminal law.[28] Today it may be more difficult to attack a provincial consent requirement on the basis of the legislative division of power between the federal and provincial/territorial governments because there is no criminal federal law on abortion occupying the field.[29] In addition, a province/territory may attempt to insulate itself by requiring the third-party consent as a precondition to abortion, rather than making its absence an offence. Despite the form of the provision or the existence or non-existence of a federal abortion law, any parental or spousal consent requirement would be suspect under the Charter. Courts in the United States have consistently invalidated state-imposed spousal consent requirements.[30] They are said to restrict a women's liberty by giving third parties an effective veto over her decision and they jeopardize her physical security to the extent they operate to delay access to a medically necessary service.[31]

Although the absence of a criminal law on abortion does not therefore create provincial and territorial jurisdiction over abortions, its effect is to allow them a wider range of legislative options, to make their jurisdiction more visible, and to increase the public scrutiny of their choices. A review of provincial and territorial responses to the *Morgentaler* decision shows how their power has been exercised in different ways and to serve different ends.[32] Some provinces, like Ontario, have used the range of regulatory options created by the absence of a criminal law to promote women's reproductive health care. In that province, abortion is seen as one of the many medical services which must be integrated into the public health-care system to accommodate the medical needs of women. Reproductive health-care clinics have been established and are publicly funded.

In contrast, some provinces have employed a variety of mechanisms to single out abortion for special treatment. Some provinces/territories have used their general power to regulate medical institutions and medical qualifications to require that abortions be performed in hospitals and/or by a specialist in gynecology or obstetrics. Other provinces require the second opinion of another physician before an abortion can be performed, while still others require a doctor performing an abortion to file a written statement that the procedure is medically necessary. In some provinces, pregnant women seeking abortions must undergo "counselling" before the operation will be authorized or performed. Special rules have been superadded, whether by statute, regulation, funding decisions, or under the umbrella term of provincial or territorial policy, to deal with what is perceived to be the unique status of abortion. Often these rules serve no medically sound purpose.

It was widely acknowledged that therapeutic abortion committees were used merely to comply with legal requirements and not because they enhanced the quality of women's health care. To the extent that new provincial and territorial regulations operate as substitutes for these defunct committees they run the serious risk of duplicating their inadequacies. Special regulations on abortions therefore may stigmatize this medical procedure, impede access to it, and create administrative delays.

This patchwork of provisions and policies suggests that there has been no dramatic increase in women's access to necessary abortion services as an immediate result of the *Morgentaler* decision. There appears to be a continuation of the uneven and inequitable availability of abortion documented in the Badgley Report[33] and the Powell Report,[34] and relied upon by the Supreme Court as a main reason for ruling that therapeutic abortion committees infringed women's rights.

Provinces may also influence reproductive health care because they determine which services are deemed to be medically necessary under the federal/provincial cost-sharing program for Canada's national health system and they establish the rate at which these services are compensated.[35] For example, in 1985, the Alberta government withdrew public funding for contraceptive counselling, sterilization operations for males and females, and the insertion of IUDs for all women who were not, by reason of a specifically enumerated medical reason, disqualified from employing oral contraceptives.[36] Although the government reinsured these services as a result of political pressure, its initial decision to withdraw funding is a good example of the potential impact of provincial powers over women's reproductive health and will be used throughout this paper. In a different context, the British Columbia government attempted to revoke public funding for abortion services after the *Morgentaler* decision. The decision to withhold funding was struck down by a B.C. court on administrative law principles because the enabling statute did not allow the government to act as it did.[37] But that case also raised numerous Charter issues because access to abortion would be seriously curtailed if individual women were forced to personally pay for medically necessary services or if doctors were expected to provide them free of charge.

Limiting funding, rather than withholding it entirely, also may have an adverse impact on the availability of women's reproductive health care. Rules concerning the tariff of medical fees may discourage doctors from performing certain types of procedures or providing certain types of services. For example, in Alberta, many doctors have stated that the provincial rate for performing abortions is too low to compensate them for the medical services provided. Doctors in one hospital in Calgary have stopped performing second-trimester abortions, citing the Alberta Health Care Insurance Plan as the reason why the procedure is "not worth the hassle".[38] In other provinces, funding controls take the form of a stipulation that public funds are only available for abortions performed in an approved hospital, but not for abortions performed in an alternative facility like a reproductive health-care clinic.

Provincial and territorial legislation, regulation, and policy address many aspects of women's reproductive health other than access to abortion. The non-criminal regulation of "prenatal" treatment provides an interesting example of how

provincial and territorial powers can operate on a woman both directly and indirectly. The *Children's Act*[39] in the Yukon Territory contains an express provision which directly authorizes the Director of Children to control the conduct of a pregnant women:

> 134.(1) Where the Director has reasonable and probable grounds to believe and does believe that a foetus is being subjected to a serious risk of suffering from foetal alcohol syndrome or other congenital injury attributable to the pregnant woman subjecting herself during pregnancy to addictive or intoxicating substances, the Director may apply to a judge for an order requiring the woman to participate in such reasonable supervision or counselling as the order specifies in respect of her use of addictive or intoxicating substances.

This provision is unique in Canada and it has not yet been challenged for compliance with Charter guarantees.[40]

Women's reproductive health also may be affected by provincial laws whose primary purpose lies elsewhere.[41] General provisions in child welfare legislation have been invoked in an indirect attempt to control the conduct of pregnant women. For example, it has been argued that a woman may be required to submit to medical treatment when provincial or territorial authorities believe her fetus may be in danger or may suffer harm without it. Some courts have interpreted child welfare legislation as allowing them to take into account the conduct of the pregnant woman when assessing whether the "child", once born, was in need of the state's protection. Under this interpretation, what happened to the fetus *in utero* was seen as evidence that a "child" was in need of the state's protection when it was born. In one specific example, a child born with fetal alcohol syndrome was judged to have been born abused. The child was apprehended at birth and was never in the custody of its parents.[42] However, there are limits to how far this line of cases can be extended.

In *Re Baby R.*,[43] the British Columbia Supreme Court held that child welfare legislation did not justify a court order requiring a pregnant woman to deliver by caesarian section. Provincial authorities could not, by seeking custody of her fetus, effectively apprehend the woman and mandate her course of medical treatment. Justice Macdonell stated:

> I conclude therefore, after examining the *Family and Child Services Act* and the other relevant law, that the powers of the Superintendent to apprehend are restricted to living children that have been delivered. Were it otherwise, then the state would be able to confine a mother to await her delivery of the child being apprehended. For the apprehension of a child to be effective there must be a measure of control over the body of the mother. Should it be lawful in this case to apprehend an unborn child hours before birth, then it would logically follow that an apprehension could take place a month or more before term. Such powers to interfere with the rights of women, if granted and if lawful, must be done by specific legislation and anything less will not do.[44]

In another case, authorities in Ontario combined a claim for custody of the fetus with a mental health warrant seeking the committal of the pregnant woman.[45] The provincial authorities alleged that the medical evidence of the woman's pain (which she denied), her erratic conduct (the evidence disclosed that she slept in a garage one night — but this may have been economically motivated), and her refusal to

seek, maintain or accept medical assistance gave them reasonable cause to believe the fetus was in danger and that she was suffering from a mental disorder. The woman was committed to await the delivery of her child.

The province's or territory's control over who may practise medicine in the particular jurisdiction also has implications for women's reproductive health care. For example, midwives may be seen as alternative medical personnel whose expertise in normal and natural birth procedures could benefit not only all pregnant women but specific groups of women, such as northern Aboriginal women, rural women and immigrant women, for whom existing maternity health care is less responsive to their needs. Many provinces are reviewing the legal status of the practice of midwifery but it has not yet been formally legalized in any province.[46]

The province's or territory's residual ability to legislate on matters of local health means that new issues concerning women's health care, such as the legal parameters for reproductive technologies, may receive the attention of provincial regulators.[47] Although questions of artificial insemination, *in vitro* fertilization, so-called "surrogacy", or preconception contracts have been studied by a few provinces, the ramifications of these reproductive technologies for women must be explored further and incorporated into any decision-making process.[48]

Health-care Professionals

It is clear that hospital administrators, professional medical associations, and individual health-care workers have a significant and sometimes a controlling influence on women's reproductive health care. Hospitals administrators have effective control over all aspects of the medical services provided in their facilities. They decide which services will be available, in what form, under what terms and conditions, in what number, and who can perform which services. The rules, procedures, and policies established by them have an impact, both directly and at the operational level, on women's reproductive health care. In every case where hospitalization is required, either legally or medically, the decisions of hospital administrators affect women. In all cases, regardless of the type of medical service sought, women will be affected by the level of services provided by the hospital in their district.

Where, for example, provincial or territorial law or policy requires abortions to be performed in hospitals, all women seeking abortions are obliged to submit to the jurisdiction of hospital administrators and hospital boards. In the past, the impact of hospitals' decisions on women's access to abortion was obvious under the therapeutic abortion committee system. Today, hospital administrators continue to decide whether any abortions will be performed in their facilities, their number or quota, what type of medical practitioner may perform them, and whether there will be specific approval procedures or additional requirements concerning consent or counselling. It is precisely at the hospital level that access to abortion is restricted in Prince Edward Island: the hospital administrators threaten to terminate the hospital privileges of any doctor who performs abortions.[49] The result is that no abortions are performed at either of P.E.I.'s two main hospitals even though the province has

not imposed any special regulatory or funding restrictions for abortions performed in the province. (The government has agreed to fund abortions performed in out-of-province hospitals if certain terms and conditions are met.)

Attitudes, approaches, and policies of individual health-care personnel also have a significant impact on the level and quality of reproductive health-care services available to women. A study of the therapeutic abortion committee procedure found that it was often the woman's own doctor who impeded access to abortion.[50] Women hospitalized for therapeutic abortions were sometimes treated less solicitously by health-care personnel, either because they were not perceived to be "sick" or because members of the staff disapproved of the pregnant woman's decision to terminate her pregnancy.[51]

While a doctor's medical judgement quite properly extends beyond strictly physiological factors, the practice of medicine has the potential to operate as a form of social control. Cases in which a physician will not perform an abortion unless the woman "consents" to sterilization, or will not sterilize a woman unless she is of a certain age or already has a designated number of children, or refuses to confer the benefits of reproductive technologies to infertile women who are not part of a stable heterosexual marriage, all illustrate how social factors can be used in medical decision-making. One commentator has suggested that the dual hierarchies in the traditional male doctor/female patient relationship result in compliant and passive behaviour which raises the larger question of the integrity and validity of certain women's consent to medical procedures.[52]

If the health-care professional has negligently performed the medical procedure and/or has negligently failed to disclose the material risks associated with it, a patient may invoke the general principles of tort law to affix liability. For example, a doctor was successfully sued for medical malpractice when he failed to take the plaintiff's application to a therapeutic abortion committee.[53] Increasingly, doctors who negligently perform abortions or sterilization operations are being held liable for some of the damage caused by the unplanned child. These are known as the "wrongful birth" cases.[54] Litigation concerning the Dalkon Shield intrauterine contraceptive device and the marketing of D.E.S. to pregnant women threaten sobering liabilities for manufacturers prepared to use women as living laboratories for their untested products. The Ontario Court of Appeal recently found Ortho Pharmaceuticals liable for its failure to disclose the known medical risks of the birth control pills it markets.[55] Forcing negligent practitioners, manufacturers, or hospitals to compensate women for damage caused in relation to reproductive health care is a powerful remedy, within the control of individual women, which encourages quality health care by deterring negligence. The recognition that these general tort law principles extend to negligent acts in the course of women's reproductive health care serves two functions: it challenges outdated stereotypes and reinforces the principle that equal value must be given to the physical integrity of men and women patients.

While coercive legal action against hospital administrators and health-care professionals is possible, the benefits of education and lobbying for change should not be forgotten. Women have been successful in demanding changes in the birthing process. Greater support for natural childbirth, choice of birthing position, and

attendance by midwives as well as provision of birthing rooms in hospitals and allowing birthing coaches in the delivery room illustrate how women's criticisms of the medicalization of the birthing process have had a positive impact on the quality of women's reproductive health care.

Summary

As this review indicates, the many sources and forms of control on women's reproductive health available to the federal and provincial or territorial governments and the health-care professionals give them wide powers to either promote or hinder women's health care. Their decisions influence how women's reproductive health care is conceptualized and administered and also directly control which health-care services are available and accessible to women.

While this overview situates the locus of decision-making for lobbying or legal challenge, it also illustrates the pattern of special regulation which emerges concerning women and their role in human reproduction. Recognizing the number, form, and extent of these controls establishes women's reproductive health as a discrete topic of constitutional inquiry and makes one more critical of arguments profferred to support restrictions on women's medically necessary services. There is no doubt that, in general, each of the three decision-makers discussed may regulate in a manner which adversely affects a certain group: the federal government may prohibit the sale of experimental medication; a provincial or territorial government may regulate the conditions under which a heart transplant is performed or decide to withdraw funding for immunizations; and hospital administrators may elect not to perform certain forms of surgery. But in the particular case of women's reproductive health it is noteworthy that all three decision-makers have acted and have done so in ways which tend to limit women's access to the medical services they require.

A provincial or territorial decision to withdraw public funding from contraceptive counselling would have a significantly different impact on the lives of women if it were the only form of regulation on women's reproductive health. Similarly, the decision of one hospital not to perform abortions would have different implications if other hospitals in the same district met the demand for this service. But, in present circumstances, each of these decisions cannot be considered in isolation; therefore, judging the impact of this type of regulation independently and in the abstract would constitute an improper measure. The many sources and forms of regulation on women's reproductive health combine and compound to form a complex web of social control. It is within this overall context in which one must consider whether the decisions of the federal government, provincial or territorial governments, or health-care professionals infringe women's rights under the *Canada Health Act* and the *Canadian Charter of Rights and Freedoms*.

The Provision of Health-care Services and the Canada Health Act

This section of the paper explores how the *Canada Health Act*[56] can be used to promote access to medically necessary reproductive health services.[57] The *Canada Health Act* reads like the *Health Charter*[58] for the people of Canada. The *Canada Health Act*'s criteria are framed in wide terms and are intended to establish broad norms of social justice. For example, section 3 states:

> 3. It is hereby declared that the primary objective of Canadian health care policy is to protect, promote and restore the physical and mental well-being of residents of Canada and to facilitate reasonable access to health services without financial or other barriers.[59]

The preamble to the *Canada Health Act* is equally explicit that "continued access to quality health care without financial or other barriers will be critical to maintaining and improving the health and well-being of Canadians".[60] The underlying philosophy of the *Canada Health Act* is therefore that all residents are entitled to universally accessible personal health services. Medically necessary services are provided based on people's medical need and not their ability to pay. Although these goals of the Act are clear, and are reflected in the five criteria of the insurance system contained in the *Canada Health Act*, the criteria are undefined and may be difficult to enforce.

The Criteria of the Canada Health Act

The *Canada Health Act* establishes the terms and conditions under which provinces must provide medical services before they qualify for full federal payments under the federal/provincial cost-sharing program established for health care in Canada. These terms and conditions are known as the five criteria of comprehensiveness, accessibility, universality, portability, and public administration. A provincial plan which fails to meet even one of these criteria is therefore in breach of the *Canada Health Act*. Theoretically, these criteria are independent and cumulative; in practice, however, the combination of clearly defined legislative goals and broadly framed criteria means there is some overlap. As each criterion is necessary to the fulfilment of the national vision of publicly funded health services, a purposive and contextual interpretation means that certain types of provincial conduct may contravene more than one criterion and, therefore, breach more than one section. Because none of the five criteria is expressly defined in the Act, each criterion must be interpreted according to the natural and ordinary meaning of the words used, the presumed intention of the legislators, and a purposive interpretation which is consistent with the other sections and reading the Act as a whole. Therefore, whether a provincial plan contravenes the *Canada Health Act* will depend primarily upon the proper interpretation and scope of these criteria.

Comprehensiveness

Section 9 of the Act specifies that, to be comprehensive, a province's health-care insurance plan must cover all "insured health services" provided by hospital and medical practitioners. This key term is defined to mean those hospital services and physician services provided to insured persons, who are defined as residents in the province.[61] The statutory criterion of comprehensiveness appears to require that the province must insure medical services provided to its residents.

There are essentially two ways to interpret this criterion. The first interpretation of "comprehensiveness" would allow the province great latitude to exclude many services. In deference to provincial jurisdiction over local health matters, "insured health services" may mean only those services which have been formally designated as such by the province. Under this argument, there is no normative content to the term "insured health services" and the province must only insure the medical services it actually decides to insure for its residents. The concept of "insured health services" becomes the federal shell into which individual provinces are free to pour their own meaning. This interpretation is unlikely to prevail because, if accepted, no provincial system could be anything but "comprehensive". If the province need only insure the services it has decided to insure, then its system could never be underinclusive. An alternative interpretation must be sought because this one tends to make nonsense of section 9 of the Act.

A second interpretation would read comprehensive coverage as requiring a certain minimal level of services — perhaps, something like complete coverage for the medically necessary services actually provided in the province. Arguably, only when comprehensiveness has such a normative content are the health needs satisfied and the goal of universally accessible medical services achieved. This approach to comprehensiveness is consistent with the *Health Charter*[62] and the report of the Royal Commission on Health Services.[63] Both of these documents helped lay the foundation for our current national health-care system and the criteria enunciated in the *Canada Health Act*. In the *Health Charter*, "comprehensive" was defined to mean "all health services, preventive, diagnostic, curative and rehabilitative, that modern medical and other sciences can provide".[64] Similarly, the Royal Commission thought the following types of programs would be necessary in a comprehensive system: medical services, dental services for children and expectant mothers and public assistance recipients, prescription drug services, optical services for children and public assistance recipients, prosthetic services, home-care services, and mental-health services. These definitions illustrate that the widest possible coverage appears to have been intended under the concept of comprehensiveness. Emmett Hall's 1980 national study on the health-care system found that extra-billing by physicians violated this criteria because "[a] program whose benefits do not meet the full costs of the services provided can in no way be considered comprehensive . . ."[65] This finding also supports the view that comprehensiveness requires provinces to insure more than what they have decided to pay for.

The normative content of what ought to be covered by a comprehensive provincial scheme may be ascertained by examining many variables:

- which medical services are actually provided in the province;
- whether the service is medically necessary for the health and well-being of the province's residents;
- whether the service is provided and insured in other provinces;
- the importance of the service to the people who require it; and
- the consequences of de-insuring the service on both its availability and the burden imposed on those people who will be forced to pay for it.

Under this interpretation, the funding decisions of certain provinces relating to women's reproductive health may contravene the criterion of comprehensiveness.

A complete withdrawal of funds, like the decision of the Alberta government to de-insure sterilizations, would constitute the most obvious form of underinclusion and noncompliance. In that case, sterilization operations continued to be provided in the medical sense but Albertans were personally obliged to pay for them. The provincial insurance plan was not comprehensive because it failed to extend its coverage to an objectively medically necessary procedure which was, in fact, provided to its residents. The same analysis would mean that the decision of the British Columbia government to withdraw all public funding from abortion also would have breached this section.

Restrictions on or partial exclusions from funding may also threaten the criterion of comprehensiveness. For example, provinces which publicly fund medical procedures such as abortions only when they are performed in hospitals may fail to pay for all medically necessary abortions provided in the province. There is a clear inference of underinclusion when the same procedure is insured if performed in one facility but not if performed in another. With regard to genuine government concern over where the service is performed, as opposed to concern over the inherent nature of the procedure, it should be remembered that the province has many ways to monitor the quality of health-care services without withholding public funding. Alternative facilities such as reproductive health-care clinics must meet general health and safety requirements, be approved by the College of Physicians and Surgeons, and are required to employ only qualified personnel.

Some cases of underfunding may also offend the criterion of comprehensiveness. Arguably, when the Alberta government pays for only one medical procedure (a second-trimester abortion) and not for a separate and subsequent procedure which is often required as a consequence of the first procedure, there is no comprehensive coverage of women's health-care needs. In one sense, the term "underfunding" in this context is a misnomer because there is no funding for medically necessary services that would be insured if performed in other circumstances.

It is less likely that the criterion of comprehensiveness was intended to cover the underfunding of particular procedures, unless the level of funding is so low in relation to its costs that one can reasonably conclude that there was no true intention to include the procedure. Because courts may hesitate to second guess the government's economic assessment of what medical services are worth, it may be difficult to question the amount of funding directed to particular procedures. Only

in a rare case can the courts be expected to intervene in this type of situation. Limited judicial review of underfunding increases the obligation on physicians and consumer groups to ensure that the true cost and the real value of medical services are reflected in the tariff established.

The difference between formal inclusion and actual coverage also arises if a province insures a medically necessary service but does not provide it. If comprehensive coverage implies the availability of services at a certain minimal level, it may be difficult to speak of a provincial health insurance plan as comprehensive when the province will pay for, but not provide, needed services. This is the paradox in Prince Edward Island where the provincial government recognizes abortion as a medically necessary service, by expressly including it in the provincial health insurance plan, but no abortions are performed on P.E.I. A woman must therefore travel to another province to obtain a service which her own provincial government recognizes as medically necessary. At a minimum, the failure to compensate a patient for travel costs in these circumstances operates as a financial penalty and extra user fee. Either this extra charge, the absence of medically necessary services, or their combination raises the important question of whether the appearance of coverage or the reality of no services should govern such determinations.

Accessibility

While the coverage or exclusion of a service is probably more closely associated with the policy and purpose of comprehensiveness, it is not the only relevant criterion under the *Canada Health Act*. The criterion of accessibility, which focuses on how insured services must be provided, is also important. However, there may be some overlap between the criteria of comprehensiveness and accessibility because, in one sense, an uninsured medical service is inaccessible to some. Section 12(1) of the Act outlines the criteria for accessibility:

> 12.(1) In order to satisfy the criterion respecting accessibility, the health care insurance plan of a province
>
> (a) must provide for insured health services on uniform terms and conditions and on a basis that does not impede or preclude, either directly or indirectly whether by charges made to insured persons or otherwise, reasonable access to those services by insured persons;
> (b) must provide for payment for insured health services in accordance with a tariff or system of payment authorized by the law of the province;
> (c) must provide for reasonable compensation for all insured health services rendered by medical practitioners or dentists; and
> (d) must provide for the payment of amounts to hospitals, including hospitals owned or operated by Canada, in respect of the cost of insured health services.

Access implies an absence of financial, geographical, and regulatory barriers. To the extent the *Canada Health Act* is Canada's "charter of health rights", this provision may be seen as its equality norm and anti-discrimination guarantee. Therefore, it can be expected to raise issues of approach and interpretation similar to those which arise under section 15 of the *Canadian Charter of Rights and Freedoms*.

There are two aspects to subsection 12(1)(a) of the Act: first, the provincial plan must provide the insured health services on uniform terms and conditions; second, the province cannot use its powers over health care to impede or preclude reasonable access to medically necessary services. In relation to the first, how the term "uniform" is defined and the choice of which insured health services must be uniformly available determines the content and extent of this protection.

In Webster's Dictionary, "uniform" is alternatively defined to mean complete conformity to a rule or pattern or consistent in conduct, character, or effect.[66] An approach to "uniformity" based on complete conformity would tend to require nothing more than formally identical treatment. Accordingly, as long as each insured service is available on the same terms and conditions there would be no breach. For example, a provincial law requiring either the approval of a second physician for all abortions or that all abortions be performed in a hospital would meet the requirement of accessibility as long as there was conformity within the designated class, i.e., that all abortions were available on identical terms. Under this approach, there would be no comparison outside the category of the procedure involved and no inquiry into the impact of the requirements imposed. If this is all the requirement of uniform terms and conditions means, then the criteria of accessibility would only operate to prevent the most blatant examples of different treatment, such as one rule for Aboriginal people and one rule for non-Aboriginal or variable terms and conditions for those in urban and rural areas.

It is much more likely that "uniformity" requires the similar treatment of like medical procedures or the more result-oriented standard of an equal availability of medically necessary services. As many commentators and courts have cautioned, restricting equality to formally identical treatment often reinforces existing inequities.[67] The Supreme Court's recognition that true equality may require more than formally identical treatment supports a larger and more liberal interpretation of the concept of uniformity.[68] A gender-neutral interpretation may actually impede the goal of quality health care for all if it fails to take into account that different health-care consumers have variable health-care needs.

The scope of the protection afforded by the requirement of uniformity will also depend on how the categories for comparisons are selected and constructed. For example, in assessing the uniformity of provincial abortion services it becomes important to question whether abortion should be compared with medical procedures of similar complexity, medical procedures performed exclusively on women, procedures relating only to women's reproductive health, procedures involving pregnant women, or procedures involving pregnant women seeking to terminate their pregnancies. However, when the reproductive health-care service being considered is abortion, the nature and consequences of the procedure may be used to argue that it is so unique it is properly in its own category. As the category widens, it becomes less likely that special regulations will meet the test of uniformity.

It is unclear how these definitional difficulties will be resolved but if "uniform" means formally identical treatment within circumscribed categories, the second condition contained in subsection 12(1)(a) may hold more promise for those seeking to challenge the special terms and conditions imposed by certain provinces on the

availability of abortion services. Stated positively, the second part of subsection 12(1)(a) grants the right to reasonable access to insured services. Under its expansive terms, reasonable access cannot be impeded or precluded, directly or indirectly, by charges or other means. Unreasonable, disproportionate, or inhibiting barriers therefore infringe this criterion whether they are economic, geographic, or legal barriers.

To determine whether access is impeded or precluded, the availability of medical services must be measured and the impact of the provincial restriction or regulation must be gauged. Singling out a medical procedure for special treatment and imposing additional or unique bureaucratic requirements would constitute *prima facie* barriers. Services may also be seen as inaccessible where individuals must travel to another jurisdiction to obtain necessary services or attend an alternative health-care facility whose costs are either outside the provincial plan or borne by the individual. Excluding or limiting funding for medically necessary services may also raise issues of accessibility as well as comprehensiveness. Requiring individuals to pay premiums or user fees was criticized by Justice Hall as a form of improper financial barriers,[69] but the principle of accessibility guarantees against more than economic impediments. Large federal transfer payments create in the provinces a heavy concomitant responsibility to provide and fund adequate services.

As specified in subsection 12(1)(a), not every barrier which impedes or precludes access contravenes the criterion of accessibility. The statutory standard is not one of free access or easy access but the relative, circumstantial one of reasonable access. Once again, it is the interpretation of this undefined term which determines the type and extent of permissible provincial restrictions. A weighing and balancing of interests is needed for all determinations of reasonableness. Borrowing approaches to reasonableness from other areas of the law (such as civil liability in tort and limitations on rights and freedoms allowed under section 1 of the Charter) suggests the following as relevant considerations:

- the nature of the medical service;
- the demand for the medical service;
- the reason for imposing the restriction;
- the consequences of the restriction;
- the extent of the impediment created;
- its impact on those affected by it;
- the importance of the insured services;
- the nature of the provincial interest alleged;
- whether the restriction is proportional to the end sought;
- if it is rationally connected to it;
- whether it is carefully tailored to impede access as little as possible; and
- the cost/benefit implications of the decision.

The expansive wording in subsection 12(1)(a) and the general purpose of the *Canada Health Act* suggest that impediments or preclusions which jeopardize the patient's health are likely to be considered unreasonable. This may include superadded requirements which do not arise from the nature of the medical procedure, which delay access to medically necessary services, and which threaten the patient's physical and psychological well-being. In *Morgentaler*,[70] the Supreme Court of

Canada criticized the *Criminal Code* requirement that abortions could only be lawfully performed in approved or accredited hospitals upon the approval of a therapeutic abortion committee. The Court held that the requirement was unfair and arbitrary and the unnecessary delay it generated improperly infringed women's security of the person contrary to section 7 of the Charter. Impediments or preclusions which infringe a Charter interest may, for that reason alone, be unsupportable under the *Canada Health Act*. In this respect, provincial requirements which limit or restrict access to abortion may breach either aspect of subsection 12(1)(a). Provinces which have a two doctor rule, a hospital proviso, spousal consent, and counselling requirements single out abortion for special treatment and impede reasonable access by lowering the overall availability of abortions in the province or making it more difficult for individual women to obtain one.

A difficult and different issue is raised by the situation in Prince Edward Island, where the inaccessiblity of abortion services is directly traceable to the hospital boards. To the extent that the decisions of hospital boards qualify as government action they will be subject to separate scrutiny for compliance with the Charter but it may be more difficult to engage the responsibility of the provincial government under the *Canada Health Act*. The province's breach would have to be based on its failure to intervene and to overrule each board's decision in light of its power to regulate hospitals and medicine. The province's inactivity may be interpreted as an implicit endorsement of the hospital's position. It is possible to argue that a province should be accountable when the *Canada Health Act* goal of secure health-care services for Canadians is jeopardized, regardless of whether that result is the consequence of its intentional conduct or tacit approval. Because the seriousness and magnitude of the inaccessibility should be considered when affixing liability, it may be easier to establish provincial responsibility when reasonable access is totally precluded rather than partially impeded. Perhaps the case is stronger in a province like Prince Edward Island where the legislature passed a resolution opposing the performance of abortions.[71]

Subsection 12(1)(c) may also be relevant to the underfunding of medical services. It requires a province to provide reasonable compensation for all insured services rendered by medical practitioners. Consequently, underfunding may offend the criterion of accessibility even if it is not prohibited under comprehensiveness.

Universality, Portability, and Public Administration

The remaining criteria of universality, portability, and public administration contained in other sections of the *Canada Health Act* may also support women's right to reproductive health services. The "universal" coverage protected in section 10 of the Act was defined by the Royal Commission in 1964 to mean "that adequate health services shall be available to all Canadians wherever they reside and whatever their financial resources may be, within the limitations imposed by geographic factors".[72] Disparate provincial access may therefore infringe this principle. Variable provincial tariffs and the rate at which one province will pay for an abortion performed in another province may also raise issues concerning the criterion of portability. A final

point should also be made concerning the criterion of public administration. This section merely requires that the provincial insurance plan be publicly administered, which all are, and not that individual medical procedures must be performed in public hospitals before they will be publicly funded.[73]

Summary

An expansive and purposive interpretation of the five criteria of the *Canada Health Act* raises the possibility of challenging certain forms of provincial regulation. To some people, it may appear that to do so would allow the federal government to infringe on provincial health powers by establishing required levels of health services within the province.[74] However, such a criticism does not acknowledge that a conditional grant, by definition and design, imposes conditions and that the natural, and perhaps the intended consequence, of any federal cost-sharing program is federal influence within areas of provincial jurisdiction. It seems an anomoly of constitutional law that the federal government may spend where it cannot legislate but provinces are, in theory, free to accept or reject the federal funds.[75] If they accept the federal money they accept it subject to the attached federal stipulations. Therefore, the federal criteria established in the *Canada Health Act* can indirectly affect provincial health-care programs.

Remedies for Breaches of the Canada Health Act

The purpose of the *Canada Health Act* is to give statutory form to the federal/provincial cost-sharing agreement on health care. The Act establishes the criteria that provincial health-care regimes must meet before the federal government will make full payment to the province. The payment of federal funds is therefore conditional on provincial compliance. In this respect, the arrangement resembles a unilateral contract between the federal and provincial governments under which the federal government pays if the provincial governments comply.

The five criteria enunciated in the Act may be contravened when:

- medically necessary services are not provided;
- these services are provided only on special terms and conditions; or
- public funding is withheld, tightly controlled, or set at unrealistically low rates.

However, where the essence of the complaint is that a province has used its jurisdiction over health in a manner inconsistent with the principles of the *Canada Health Act*, the purpose and structure of the Act may prevent individuals from seeking effective legal redress, especially if their claims are based solely on its provisions.

Although persons in Canada are intended to benefit directly from the criteria and provisions of the *Canada Health Act*, their position is akin to that of any third party beneficiary under a contract — they have an interest which can only be enforced with great difficulty. The remedies section of the *Canada Health Act* confirms that the Act is intended to establish the obligations between governments. Section 15 gives no discrete enforceable legal rights to provincial residents: it merely

allows the federal government to "fine" provinces which violate the Act's specific criteria by withholding either part or all of the full federal contribution. The *Canada Health Act* therefore provides no recognized mechanism by which complaints may be voiced when the Act's provisions are not respected or when reimbursement or compensation are sought when individuals are forced to personally pay for uninsured or unavailable medical services. The insignificant number of reported cases on the *Canada Health Act* attest to its limitations as a tool to redress the grievances of individual complainants.[76]

A complainant looking to the courts to remove improper provincial barriers therefore must look outside the terms of the Act as the following analysis will illustrate. An individual complainant will have difficulty establishing a recognized legal right and claiming an effective legal remedy against either the provincial or federal government. Some type of enforcement mechanism, preferably in the Act itself, which would allow individuals to insist on compliance or compensation is needed to fully protect the health interest the Act was intended to safeguard. Currently, individual complainants have the choice of defendants and several different ways to frame their legal action. The federal/provincial nature of the health-care system suggests proceeding against either or both levels of government. Their activities may be questioned primarily for compliance with administrative law principles and the guaranteed rights and freedoms in the *Canadian Charter of Rights and Freedoms*.

The Provincial Government

Provinces have a significant impact on the provision of adequate reproductive health-care services. They decide what qualifies as medically necessary services, the circumstances under which there will be "insured health services" under the *Canada Health Act*, and the rate or tariff at which health-care professionals will be remunerated. The exercise of such provincial power usually takes the form of a regulation enacted under the provincial health insurance act.[77] When services are unavailable, insufficient, or inaccessible, the offending provincial law, policy, or decision can be challenged directly. The legality of the provincial regulation depends upon whether that government has the authority to enact the regulation, whether the provincial regulation complies with the criteria in the *Canada Health Act*, and whether the government's action respects women's constitutionally protected Charter rights.

When the British Columbia government withheld public funding from abortions after the *Morgentaler* decision, an administrative law action was taken to challenge the legality of the regulation.[78] The legal argument focussed on whether the way in which the provincial Cabinet de-insured abortion was within the scope of its statutory powers. The Court carefully examined the source and extent of the Cabinet's powers, questioned whether proper procedures were followed, and concluded that the Cabinet had exceeded its statutory mandate. In this type of legal challenge, the court's decision often appears to be rather technical as the judicial inquiry is limited to the question of the decision-maker's jurisdiction. In the majority of such cases, the content of the provincial or territorial regulation is not

assessed or its potential impact evaluated. In addition to a circumscribed ambit of judicial review, the scope of administrative law remedies is somewhat limited and may not serve the long-term interests of the complainant. Usually the remedy is to strike down the illegal or *ultra vires* regulation. This remedy is of obvious immediate benefit because the offending limitation can no longer operate. But the British Columbia government could have reintroduced the same type of funding limitation if it acted within the terms of its statutory powers. In some cases, simply striking down the regulation in the form it was enacted is the desired remedy; in some cases, the government may not try again. But because not every provincial or territorial limitation is open to this type of review or responds to this type of remedy, alternative legal arguments and remedies must be examined.

When a provincial decision contravenes the criteria in the *Canada Health Act*, the province may be acting illegally. It is important to remember that because provinces have jurisdiction over health matters, they may either accept or reject the federal funds and the federal stipulations outlined in the *Canada Health Act*. Therefore, there would be no cause of action if the province chose not to insure certain medically necessary services and received less federal money as a result. However, there may be cause for complaint where a province is claiming and receiving full federal contribution at a time when it is contravening the Act's criteria. Arguably, the breach of the Act's criteria may make the federal payment and provincial receipt of contributions unlawful but the availability and efficacy of any remedy against the provincial government may be problematic.

It may be possible to obtain a declaratory judgement under which the court declares that the receipt of full payment is illegal. Such a judgement may encourage the province to change its policy, but it does not operate in law to invalidate the offending regulation. Such a declaration could be accompanied by a request for an injunction against the receipt of the money by the province. To benefit individual claimants, additional forms of relief may be invoked although they would require a creative extension of certain causes of actions and legal principles. Some examples would include: claiming tort damages by arguing that the provincial government's activities constituted a negligent breach of its public duties which have caused compensable damage to those forced to personally pay for uninsured services or to travel elsewhere, or an equitable claim for reimbursement because the province is unjustly enriched by receiving full federal payment when providing partial service.

In a 1989 court action, Dr. Henry Morgentaler challenged the New Brunswick government's policy of not reimbursing physicians who perform out-of-province abortions unless the abortion was performed under certain specified terms and conditions.[79] In a suit to recover medical fees for abortions performed on New Brunswick residents in his Montreal clinic, he sought a declaration that the provincial policy was void insofar as it purported to apply to abortions performed outside New Brunswick. The government refused payment because of its "policy" that no abortion would be recognized as an entitled service unless two physicians state that the abortion is medically required and the procedure is rendered in an approved hospital by a specialist in gynecology and obstetrics. The "policy" was not authorized by statute or regulation and the government did not expressly or

formally adopt it. The Court refused to give the New Brunswick policy extra-provincial effect. Justice Stevenson commented:

> It is unrealistic to superimpose New Brunswick regulations or policies in respect of services furnished to a resident while she is temporarily absent from the Province. The doctor who furnishes such services, and the patient who receives them, should not be denied Medicare benefits merely because something that is legally done in the other jurisdiction is in some way out of line with a policy being followed in New Brunswick.[80]

Although Dr. Morgentaler was successful, the usefulness of this decision for further court challenges in different circumstances may be limited because this case concerned the particular problems of a provincial "policy" and out-of-province abortions. This case does not address whether these same criteria would be valid if applied to abortions performed in New Brunswick and whether similar restrictions would be valid if they were imposed by changing the legislated definition of "entitled services" and transforming the policy into law. However, the decision does show a judicial willingness to question the funding decisions of provincial health regulators.

The Federal Government

A complainant may also try to force the federal government to use its powers under the *Canada Health Act* to supervise provinces in breach of its principles and to withdraw either part or all of the federal funds paid to them. However, any action taken against the federal government, even if successful, would have no direct effect on the impugned provincial regulation. This means that the most a complainant can expect is that illegal overpayments to offending provinces may cease. So even if the federal government could be ordered to levy a fine against the offending province, other legal means would be required to strike down the offending provincial regulation or enforce a mandated level of services. If these legal means were successful, offending provinces would then have to decide whether they are prepared to carry the costs of their contravention.

Although the Supreme Court of Canada has indicated that a taxpayer may have the requisite standing to challenge this type of government decision, there may be few grounds on which to do so because the *Canada Health Act* is stated in permissive terms.[81] Section 15 of the Act does not require the federal government to fine a noncompliant province. Instead, the Cabinet is given a choice whether or not to impose a fine. Section 15(1) reads:

> 15.(1) Where, on the referral of a matter under section 14, the Governor in Council is of the opinion that the health care insurance plan of a province does not or has ceased to satisfy any one of the criteria described in sections 8 to 12 or that a province has failed to comply with any condition set out in section 13, the Governor in Council may, by order,
>
> (a) direct that any cash contribution or amount payable to that province for a fiscal year be reduced, in respect of each default, by an amount that the Governor in Council considers to be appropriate, having regard to the gravity of the default; or

(b) where the Governor in Council considers it appropriate, direct that the whole of any cash contribution or amount payable to that province for a fiscal year be withheld.

According to administrative law principles, this discretion means the federal government's principal obligation is merely to consider in good faith whether a fine should be imposed. The presence of this discretion may therefore limit judicial review and preclude effective remedies.

The permissive nature of section 15 is also a major reason why a similar recent decision may not apply to federal payments under the *Canada Health Act*. A court challenge to the legality of federal contributions under the Manitoba Social Assistance Program was successful in the *Finlay* case.[82] Mr. Finlay claimed that a provincial practice of requiring deductions for previous overpayments was illegal under the terms of the federal/provincial arrangements for social services. The Court awarded a declaration that full federal payment was illegal and combined it with an injunction to stop the illegal payments. The Court held that transfer payments made by the federal government to the province were made without statutory authority because the province had failed to fulfil the undertakings upon which the transfer payments were conditional. The appropriate federal Minister was ordered to refrain from making any further payments to the province until the provincial breach ended. Despite obvious parallels between the *Finlay* case and certain provincial regulations on such matters as abortion and contraceptive counselling, the availability and terms of any such declaratory and injunctive relief in the context of the federal/provincial funding agreement on health care will be affected by the discretion under section 15 of the Act. Therefore, the federal government may have complied with the *Canada Health Act* if it has considered whether to invoke its discretion to fine the province under section 15. If the federal government has a legally valid reason not to impose a fine, its discretionary decision may be lawful.

Political Avenues

A court challenge is not the only way to bring provincial activities to federal attention. A federal review could be encouraged by political means as well as required by legal ones and any resulting federal fine would make a strong statement to the offending province. Political lobbying efforts may also be beneficial because they can be directed towards an end other than the fine against the province envisioned in section 15 of the *Canada Health Act*. For example, the federal government could be asked to declare that women's reproductive health care qualify as medically necessary services, to use the fines levied against offending provinces to reimburse the individuals who were prejudiced by provincial policies, and/or to establish model tariffs for certain medical services. The federal government could be asked to amend the *Canada Health Act* to ensure women's equal access to reproductive health care. Although the anology is not perfect, there is a precedent for such amendment in the case of extra-billing. Interesting parallels exist between the two cases and the federal government did find the political will to legislate against extra-billing. Emmett Hall's 1980 report concluded that extra-billing was a significant threat to the availability of a truly national public health-care system.[83] The Report recommended the abolition of extra-billing, arguing that its continuance

would create a two-tiered system of medical services — one for the poor and one for those willing and able to pay for medical services. Extra-billing was thought to inhibit reasonable access to services and, therefore, was contrary to the intent and purposes of the *Canada Health Act*. The federal government acted even though extra-billing did not occur in every province, or in every province at the same level, and even though certain groups vocally and vociferously opposed any legislative intervention to ban extra-billing.

In 1977, the Badgley Committee submitted its report on the functioning of the therapeutic abortion committees. Although it inquired into the operation of the now-defunct section 251 of the *Criminal Code*,[84] its conclusions concerning provincial and regional disparities on access to abortion may be equally germane under the current system. Because women's various reproductive health-care needs account for a large proportion of their medical needs, special regulations for certain procedures may also create a two-tiered system of medical services divided on the basis of gender. The special treatment of women's reproductive health care by some provinces also inhibits reasonable access to the services needed by women and, therefore, is contrary to the intent and purposes of the *Canada Health Act*. Access problems do not exist in some provinces, but have become pressing in others. Similarly, some people oppose public funding for contraceptive counselling, sterilization, and abortion. The willingness of the federal government to invoke its jurisdiction to deal legislatively with access difficulties will probably depend upon the importance it places on funded access to women's reproductive health care, the priority it places on women's rights, its understanding of federal/provincial relations, and its response to provincial claims of federal economic pressure. There is no doubt that it will be more difficult to have these arguments accepted in the context of women's reproductive health care rather than extra-billing because it may be perceived as a "women's issue" (not a so-called "people's issue" such as extra-billing which affects all citizens) and because the abortion operation may be seen as controversial. Nevertheless, political avenues should not be discounted or forgotten.

The Provision of Health-care Services and the Canadian Charter of Rights and Freedoms

The *Canadian Charter of Rights and Freedoms* is a powerful tool to effect social change and stimulate public awareness. It gives individual complainants a direct means to challenge government action and it often forces the government to publicly explain and account for its position. The Charter provides complainants with broad grounds of review as well as efficacious remedies. The content and substance of an impugned regulation is open to judicial scrutiny and, if it is found to infringe Charter protections, it can be invalidated. For example, the decision of the Alberta government to de-insure sterilization procedures could have been challenged on the basis that it infringed women's Charter rights. Similarly, a complainant may allege

complainant may allege that full payment by the federal government may breach Charter guarantees if the criteria of the *Canada Health Act* are not respected by a province.

Three basic questions provide the fundamental structure for any Charter analysis.

First: Does the Charter apply to the impugned decision? This depends on whether the decision qualifies as "government or state action".

Second: Has there been a breach of a guaranteed right or freedom? The content of the right and the nature of the limitation will determine whether the Charter section has been infringed. The Supreme Court has stated on numerous occasions that a purposive interpretation of Charter protections is appropriate.[85] The Court is guided by the remedial purpose behind a Charter section and, when construing its terms, will be influenced by the nature of the interest it was intended to protect.

Third: If a deprivation of a Charter right occurs, can the offending decision be saved under section 1 as a reasonable limitation prescribed by law and demonstrably justifiable in a free and democratic society? At this third stage of the constitutional inquiry, the burden of proof is on the government to demonstrate the sufficiency of the state interest it asserts and to establish that the means employed are proportionate to the ends sought. To do so it must prove that the means chosen are rational, fair and not arbitrary, that the legislation impairs the right or freedom under consideration as little as possible, and that the effects of the limitation upon the relevant right or freedom are not out of proportion to the desired objective. In short, the complainant bears the onus of showing that her rights have been infringed and then the government is called upon to demonstrate why it should be allowed to override constitutionally protected interests. Any unjustified infringement of a Charter right triggers the judiciary's panoply of remedies.[86]

The Application of the Charter

The reach of Charter protections to all levels of decision-making on women's reproductive health care may be problematic because it raises the larger and yet unresolved question of the scope of the Charter's protections and its proper sphere of application. What is clear is that not every activity which restricts rights or limits freedoms can be challenged for noncompliance with the Charter. The accepted role of a constitutional instrument like the Charter is to regulate the relationship between persons and the state. This suggests that there must be some component of a governmental function before decision-makers are bound to respect Charter guarantees. Under this reasoning purely "private" activities, such as those which involve only individuals and not the government, are not caught by the Charter. But the scope of Charter protections is still very much in doubt and it is the subject of strong and well-reasoned argument on all sides of the debate.

Even the sections in the Charter directed towards its own application are open to competing interpretations. Section 32(1) states:

> 32.(1) This Charter applies
>
> (a) to the Parliament and government of Canada in respect of all matters within the authority of Parliament including all matters relating to the Yukon Territory and Northwest Territories; and
>
> (b) to the legislature and government of each province in respect of all matters within the authority of the legislature of each province.

Section 52(1), which is also relevant to this discussion, stipulates that:

> 52.(1) The Constitution of Canada is the supreme law of Canada, and any law that is inconsistent with the provisions of the Constitution is, to the extent of the inconsistency, of no force or effect.

A 1986 decision of the Supreme Court of Canada requires state or government action before compliance with the Charter is necessary.[87] Under this government action test, there should be little difficulty qualifying most activities of the federal and provincial or territorial governments as state action. The Charter will apply to the federal and provincial or territorial controls over women's reproductive health contained in statutes, regulations, or executive decisions described in the previous sections. Section 32 of the Charter makes it clear that Parliament and the provincial or territorial legislatures are bound by the constitutional norms it establishes. In conjunction with section 52, it therefore is apparent that any legislation, regulation, or executive decision of the federal or provincial/territorial government must conform with women's rights under section 7 and equality rights under sections 15 and 28.

It will be significantly more difficult to establish that decisions taken by health-care professionals qualify as government action because it is difficult to predict precisely where or how the courts will draw the line between the government action caught by the Charter and the private action outside it. In *Dolphin Delivery*,[88] the Court merely established state action as a requirement without defining its context or delimiting its scope.

Constitutional experts have criticized just such a government action requirement because the absence of a principled way to differentiate the public sphere of government activity from the private sphere of individual activity makes the government action test unworkable.[89] Critical scholars have argued that the state/private demarcation is unfair because it entrenches inequality and purports to justify existing structural inequities by artificially allocating them to the private sphere where they are beyond review.[90] What is referred to as "private power" is, in reality, public power that has been delegated to certain individuals and that can be wielded in a largely unchecked and undemocratically unaccountable way. Feminist writers have also explained how distinctions between public and private spheres have been particularly harsh on women.[91] So much of the historical and systemic discrimination against women has been supported by an ideology where there was a private sphere with a separate role for women. By deciding that Charter provisions will not extend into what courts will define as the private sphere, the usefulness of the Charter as a tool of social change may be diminished. It means that the Charter

guarantees of individual rights and equality rights may only safeguard women's interests to the extent that the government has already acted to affect those interests.

Different approaches to defining a government function have been articulated and it is difficult to predict which is likely to prevail. However, one can expect courts to seek a sufficiently direct and close connection between the decision taken by the health-care professionals and the status of that decision as government action. To judge the level of connection, one must scrutinize how health care is administered in each province or territory, and consider the nature and origin of the decision and its potential effects.

Because hospital boards' activities appear to be more publicly than privately oriented, it will be easier to argue that certain activities of the boards qualify as government action than it will be to impose Charter obligations on individual health-care workers. In this context it is important that hospital boards often derive their authority from provincial or territorial laws.[92] It has been argued that any decision made pursuant to a derivative statutory power should automatically qualify as government action.[93] Because the province or territory can only bestow powers it possesses, the hospital board's grant is subject to the same limitations as the province or territory: that it must act in a manner consistent with Charter guarantees. Even if every express statutory delegation of power does not automatically trigger the Charter, the presence of a statutory power will probably be seen as an important indicator of a government function.

One may also look beyond the source of the hospital board's decision-making authority. Under a "points of contact" approach, one seeks the similarities between the decision-making authority of a hospital board and government action across a wide range of issues. The links to a customary government function are sought, tabulated, and assessed to determine whether they are sufficient in total to qualify the operation as governmental. Using this approach, the nature of the board's activity and the extent to which it is controlled or supervised by the government are important considerations.

Under a purposive approach,[94] the question is *"whether the particular activity is one to which the particular constitutional guarantee alleged to have been violated ought to be relevant"* (emphasis in original).[95] For example, because the primary role of hospitals is to provide quality health-care services for those in need, decisions of a hospital board which affect a patient's life, liberty, and security of the person and her right to the equal benefit of the law would be suitable subjects for Charter review. Other board decisions which are not so vitally linked to the purpose of hospitals may not warrant the application of Charter protections. Therefore, the Charter could be made to apply to those hospital activities which significantly affect the rights and freedoms it protects and only to the extent that they do so.[96]

Emphasizing the Charter interest protected also means that whether the activities of the hospital board are governmental will depend on the circumstances. This flexibility is desirable because any test which requires a categorical statement that a hospital board is either always acting as a government agency, or that it never is, may result in a reluctance to impose Charter obligations. Focussing on the purpose of the Charter section also provides the principled perspective necessary to uncover

and weigh any government links which exist, encourages a consideration of the consequences of a finding that an act is not state action, and makes the abstract classification of a power secondary to whether a deprivation of a protected interest has occurred.

In a recent case, a hospital by-law imposing mandatory retirement was seen as government action and was successfully challenged under the Charter.[97] On the threshold issue of whether the Charter applied, the Court asked whether the disputed by-law was "governmental in nature". The Court required and found a direct and precisely defined governmental connection. However, the fact that the hospital's ability to make this by-law derived from statutory authority was not, in and of itself, treated as sufficient to trigger Charter protections. The Court scrutinized the extent of governmental control over the Board generally and how it was used to impose the mandatory retirement policy. Although this case deals with the hospital's decision-making authority over its medical staff, there is no reason why its rationale and reasoning cannot be extended to certain board decisions concerning medical services and patient care.[98]

The proposition that hospital board decisions which directly affect the lives of patients may be considered government action is supported by cases recognizing that decisions of bodies, such as the College of Physicians and Surgeons which affect the livelihood of professionals, also attract Charter protections.[99] While these cases may hold promise for those seeking to require hospital administrators to respect Charter rights, they also stand as a caution that the application of the Charter cannot simply be assumed.

Using these same tests, it will be most unlikely that the Charter can be made to govern the conduct of health-care professionals even though these professionals represent the health-care system to individual patients. The practice of medicine is, first and foremost, a private profession and the links between the nurse's or physician's role and government action are simply too attenuated.[100] Physicians appear to be independent private actors, rather than employees of the government, even though they are paid from public funds, may have admitting privileges to public health facilities, and may be seen as providing essential public services. The same can be said of other medical professionals. However, the inapplicability of Charter protections does not leave individual women completely without legal redress. Because provincial or federal human rights legislation prohibits discrimination between private persons, a complainant may consider the terms of relevant legislation in a case where her rights are denied. The wording of the legislation and the type of infringement alleged will determine if her case falls within the statutory terms.[101]

The Principles of the Charter

The *Charter of Rights and Freedoms* is an instrument intended by its framers to eliminate or ameliorate disadvantage. Under a purposive approach to sections 7, 15 and 28, women are entitled to the full amplitude of life, liberty, security of the person, and of equality. Thus, these sections should be used to accommodate and

incorporate women's biological capacities, overcome the historical and systemic discrimination against women, and address their material inequality. Sections 7, 15, and 28 are therefore highly relevant to women's reproductive health. A theory of women's reproductive rights which emphasizes reproductive control and sex equality will be suggested and an overview of the limitations which may justifiably restrict the full exercise of those rights will be briefly presented.

Section 7 and Individual Rights

Section 7 of the Charter provides that "[e]veryone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice." Under section 7, the court attempts to give meaning to each part of the separate but closely related interest protected in it.[102] When defining the content of the rights outlined in section 7, many courts, including the Supreme Court of Canada, have examined the rights that persons have had at common law or by statute. On the basis of this review, the Court questions whether the interest claimed is so deeply rooted in the traditions and conscience of our people as to be ranked as fundamental and protected as such.[103] Although this approach to section 7 may be used to improperly thwart the emergence of new rights,[104] in appropriate cases it can help to ensure that existing rights are enforceable. Using this approach to section 7 in the context of women's reproductive health care, the provisions and criteria of the *Canada Health Act* may be invoked to determine the extent of existing legal rights to health care and to establish our commitment to publicly funded health care for all persons in Canada. In this way, the Act's criteria of universality, accessibility, and comprehensiveness could be used to help define the content of everyone's "right to life, liberty and security of the person" in the health-care context. The government's self-imposed health-care obligations and liabilities would form the basis of those rights, dispelling any concern about creating new constitutional rights to health care from whole cloth.

In *Morgentaler*, the majority of the Supreme Court relied upon section 7 to invalidate section 251 of the *Criminal Code*,[105] the federal criminal prohibition against having or performing a non-therapeutic abortion. Each of the three majority judgements (Chief Justice Dickson, Justice Beetz, and Justice Wilson) contains different reasons why section 251 infringed women's section 7 rights. The differences between the multiple judgements makes it difficult to state exactly what the *Morgentaler* decision means, even if another federal criminal law provision on abortion was in issue. It is even less clear what the *Morgentaler* decision means if the Charter challenge concerns provincial health regulations — especially since two of the majority judgements restricted their comments concerning women's section 7 rights to the criminal justice context.

Chief Justice Dickson concluded that the purpose and operation of section 251 interfered with women's physical integrity and psychological well-being which were protected under "security of the person" because:

> [f]orcing a woman, by threat of criminal sanction, to carry a foetus to term unless she meets certain criteria unrelated to her own priorities and aspirations, is a profound interference with a woman's body and thus a violation of security of the person.[106]

In Justice Beetz's view, section 251 improperly infringed a pregnant woman's "security of the person" because the criminal law restricted access to a medically necessary service.[107] He believed that a pregnant woman who requires an abortion for a medical reason (based on either physical or emotional health reasons) cannot lawfully be presented with the choice of either obtaining an illegal abortion, with its attendant risk of criminal sanction, and being forced to suffer the physical and psychological consequences of the significant and unnecessary delays caused by the procedural requirements of the therapeutic abortion committee system.

Both judges held that the therapeutic abortion system operated outside the principles of fundamental justice because it created unnecessary delays and restricted access to abortion in an unfair and arbitrary manner. The statutory requirement of an "approved" or "accredited" hospital and requiring at least four physicians to authorize and perform an abortion meant that a significant percentage of Canadian hospitals did not, by law, qualify to have a therapeutic abortion committee. In many cases, hospitals which did qualify did not establish a committee, or one was established but it did not function, or quotas were imposed.

Chief Justice Dickson believed a further flaw was the inadequate, undefined, and ambiguous decision-making standard which required that the continued pregnancy jeopardize the woman's "life and health" before a lawful abortion could be authorized. Therapeutic abortion committees adopted their own widely divergent definitions of this term and women did not know in advance which standard of health would be applied. Justice Beetz did not have the same response to the imposition of such a decision-making standard. He believed the state interest in the protection of the fetus would justify a requirement that the necessity of the abortion operation be ascertained by independent medical opinion. When the law limits why a woman may obtain an abortion, an administrative structure designed to ensure compliance with the imposed decision-making standard is normally seen as a logical consequence. According to Justice Beetz, the inevitable delay caused by a proper review process would be constitutionally acceptable.

In contrast, Justice Wilson asked whether a pregnant woman can, "as a constitutional matter, be compelled by law to carry the foetus to term against her will . . ."[108] She believed that section 251, at a minimum, violated a pregnant women's physical and psychological security of the person. Relying primarily upon American constitutional authorities, she decided that section 7 gives pregnant women a right to choose to terminate their pregnancies as a protected aspect of their "liberty".[109] This liberty "guarantees to every individual a degree of personal autonomy over important decisions intimately affecting their private lives".[110] She explained how the right to make fundamental personal decisions without state interference is a necessary aspect of human dignity, a prerequisite to pursuing one's own beliefs and ideas of a full and rewarding life and the basis of numerous other Charter sections.

Justice Wilson explained why the decision of a woman to terminate her pregnancy falls within this protected class:

> This decision is one that will have profound psychological, economic and social consequences for the pregnant woman. The circumstances giving rise to it can be complex and varied and there may be, and usually are, powerful considerations militating in opposite directions. It is a decision that deeply reflects the way the woman thinks about herself and her relationship to others and to society at large. It is not just a medical decision; it is a profound social and ethical one as well. Her response to it will be the response of the whole person.[111]

The criminal law on abortion violated a woman's liberty interest because it took a personal decision away from her and gave it to the therapeutic abortion committee. It also infringed her "security of the person" because it treated her as a "passive recipient of a decision made by others as to whether her body is to be used to nurture a new life".[112] The abortion decision was also seen by Justice Wilson as a matter of personal morality and individual conscience within the protection of section 2(a) of the Charter.[113] Section 251 of the *Criminal Code* breached section 2(a) because the state, in enacting this criminal law prohibition against abortion, was endorsing and enforcing "one conscientiously-held view at the expense of another".[114] In so doing, it improperly treated a woman as a means to an end — the reproduction of successive generations — and not as an individual with the right to make essential private decisions in a free and democratic society. These comments of Justice Wilson were not expressly restricted to the criminal justice context and therefore may have a wider application.

Using the common features of the majority decision in *Morgentaler*, one can conjecture that provincial or territorial restrictions which impair a woman's health may violate her security of the person. If one may extend the comments and reasoning of Justice Beetz outside the criminal justice context, it would seem that access to medically necessary services cannot be unfairly delayed without running the risk of breaching section 7. The factors canvassed to determine whether the provincial system is comprehensive, accessible, and universal under the *Canada Health Act* should also be considered under section 7 of the Charter. Rules requiring abortions to be performed in hospitals or with the consent of two physicians may create unnecessary delay which in turn generates both physical and psychological harm (the abortion operation becomes less safe and more difficult as the pregnancy progresses). Superadded provincial or territorial requirements which result in delayed, impeded, or precluded access to medically necessary reproductive health care may therefore jeopardize a woman's "security of the person".

Other restrictions may also infringe a woman's section 7 "liberty" interest. Withdrawing funding for IUDs on the presumption that women should employ oral contraceptives places a state-imposed fetter on contraceptive choice, a choice which may also threaten her security of her person if one considers the health implications and the medical side effects of oral contraceptives. Requiring the consent of a third party, such as a husband or parent, before reproduction-related health services will be performed also impairs the woman's control. Spousal consent requirements to sterilization or abortion effectively allow the husband or biological father to veto the woman's decision. The notion that one person can dictate the conduct of another, or

substitute his judgement for hers, is foreign to our conception of rights and liberties.[115] Statutes requiring the husband's consent before an abortion will be performed have been consistently invalidated in the United States because they improperly constrain the pregnant woman's control of her body and restrict her ability to freely decide a matter of personal concern.[116] A similar analysis of the woman's right to liberty and security of the person under section 7 of the Charter can be expected.

A related matter is where the province or the hospital has a mandatory "counselling" process before an abortion will be approved or performed. The acceptability of such a program depends upon its purpose and content. "Counselling" is often nothing more than an attempt to dissuade the pregnant woman, force her to change her mind, or delay her. It often does not truly have her interests or medical needs in mind and can be used as a vehicle to impose the values of others. For example, under the guise of mandatory "counselling", the proposed and invalidated Saskatchewan legislation would have required a pregnant woman to be provided with information on the medical risks associated with abortion, but not with information on the medical risks of childbirth. The attempt to manipulate reproductive control through this form of counselling has been invalidated in some U.S. cases as an unlawful and unconstitutional infringement of a woman's rights.[117]

While U.S. cases defining a liberty interest in relation to abortion, third-party consents, and counselling requirements are equally applicable to the Canadian context, our courts should not adopt the U.S. jurisprudence on the issue of public funding for abortion. After the United States Supreme Court decision in *Roe v. Wade*[118] established a constitutionally recognized right to an abortion, the same court subsequently upheld the denial of public funding for abortion as a legitimate allocation of public funds, one which did not violate the due process and equal protection components of the Fifth and Fourteenth Amendments in the U.S. Constitution. The Court reasoned that the absence of public funding imposed no state-initiated restrictions on access to abortion.[119]

The material differences between the U.S. medical system and our own as well as between the United States Constitution and the Charter make that line of U.S. cases inappropriate. The United States has no equivalent to the *Canada Health Act*, with the result that the floor of health-care benefits established under the U.S. system is several stories below that which exists in Canada. In addition, the U.S. Constitution does not grant the same level of protection to equality rights as does the Charter. It has been said that the U.S. equal protection clause is the "last resort of constitutional arguments".[120] In contrast, sections 15 and 28 of the Charter make equality an important, and perhaps even the primary, organizing theme of Canadian democracy. There are even signs that, despite this lower level of health-care benefits and lower level of judicial scrutiny for equality interests, the U.S. courts may be rethinking this position. In a 1981 U.S. case, the withdrawal of state funding for abortions was struck down on the ground that states may not use their wide legislative powers to burden the exercise of fundamental privacy rights in a way which is discriminatory.[121]

The freedom to choose between unavailable services does not ameliorate the condition of the disadvantaged or improve the life circumstances of women. Any section 7 argument on women's reproductive health, especially when the availability of services is in issue, should focus on reproductive **control** rather than reproductive choice. Choice may be seen as the minimum standard but it is clear that it has become an inadequate proxy for control because abstract choice can exist within the most limited range of possible alternatives. Therefore, a shift from the lexicon of choice to the language of control may be warranted and it can be expected to have both legal and political implications.[122]

Sections 15 and 28, and Equality Rights

An argument based on sections 15 and 28 could also be raised against government action which outlines special regulations for women-specific or women-directed medical procedures. Section 28 provides that the rights and freedoms referred to in the Charter are guaranteed equally to male and female persons. An argument can be made that section 28 is breached when provincial health policies impose special burdens on women's section 7 claim to "life, liberty and security of the person". Arguably, there is no shared or equal protection for legal rights when there are distinct requirements and differential access for the health services women require to exercise their reproductive control. However, any section 28 argument should be approached with some caution. Because men cannot reproduce by themselves, any interest framed in terms of a "right to reproduce" may imply that they have rights over women. Therefore, a section 28 argument should focus on the equal right to reproductive control to forestall any such implication. Section 28 does not require that parties be similarly situate before they can be compared, making section 28 a promising avenue of argumentation in relation to different biological capacities.[123]

A more developed equality argument may be made under section 15. Section 15 of the Charter provides:

> 15.(1) Every individual is equal before and under the law and has the right to the equal protection and equal benefit of the law without discrimination and, in particular, without discrimination based on race, national or ethnic origin, colour, religion, sex, age or mental or physical disability.
>
> (2) Subsection (1) does not preclude any law, program or activity that has as its object the amelioration of conditions of disadvantaged individuals or groups including those that are disadvantaged because of race, national or ethnic origin, colour, religion, sex, age or mental or physical disability.

Just like the section 7 analysis, the criteria of the *Canada Health Act* may be invoked to give content to section 15 equality guarantees. While all the criteria of the Act are applicable, the criterion of accessibility is perhaps most relevant. To judicially enforce the self-imposed criteria contained in the *Canada Health Act* would not create a new governmental liability of vast proportions. The court would not be imposing a novel positive obligation on provincial governments, it would merely be enforcing an undertaking which they assumed voluntarily and under which they receive the benefit of full federal financial contributions. As a result, the criteria in

the Act can be incorporated into the Charter analysis as the government's recognition of the floor beneath which health-care benefits may not drop. Thus, section 15 can be used to reinforce the province's requirement to provide health-care services on equal terms and conditions.

Issues of inequality before and under the law and the equal benefit and protection of the law arise on both enumerated and unenumerated grounds of prohibited discrimination. The recent Supreme Court decision in *Andrews v. Law Society of British Columbia*[124] confirmed that certain types of unenumerated categories merit constitutional protection. Unenumerated grounds relevant to provincial or territorial regulation over women's reproductive health may include residence and socio-economic status. Enumerated grounds include sex and age.

While disparate access to medically necessary reproductive health-care services exists between provinces and territories, residence may not qualify as a ground of discrimination recognized under section 15 because diversity on matters within provincial or territorial jurisdiction is generally to be expected. But where a recognized national standard exists and where provinces have undertaken uniform obligations under a plan like the federal/provincial cost-sharing programs, interprovincial comparisons may be more appropriate than in the general case. Nevertheless, it may be difficult to make an analogy between provincial or territorial residence and the enumerated grounds in section 15, a task which the Supreme Court suggests forms part of the test of recognizing an unenumerated ground of distinction.[125] It may also be difficult to speak of all provincial or territorial residents as the type of powerless, "discrete and insular minority" to which the Supreme Court has said the Charter's equality protections will be extended.[126] However, it may be easier to establish protections on the basis of residence within a particular province or territory, such as divisions based on urban or rural residence, because they do not raise issues relating to division of power or jurisdiction.

The principles of section 36 of the *Constitution Act, 1982* may be invoked to support the recognition of provincial or territorial residence as an unenumerated ground meriting constitutional protection. Section 36 reads:

> 36.(1) Without altering the legislative authority of Parliament or of the provincial legislatures, or the rights of any of them with respect to the exercise of their legislative authority, Parliament and the legislatures, together with the government of Canada and the provincial governments, are committed to
>
> (a) promoting equal opportunities for the well-being of Canadians;
> (b) furthering economic development to reduce disparity in opportunities; and
> (c) providing essential public services of reasonable quality to all Canadians.

This provision establishes a federal/provincial or territorial commitment to standardized services. Promoting equal opportunities for the "well-being" of Canadians has an obvious physical component and relates directly to health services. Subsection 36(1)(c) operates as a general reaffirmation of the principle of regional equality articulated by the criteria of comprehensiveness, accessibility, universality, and portability in the *Canada Health Act*. Therefore, this section may provide some support to a constitutional grouping around residency.

Provincial and territorial funding and regulatory restrictions may also create hardship on the basis of socio-economic status because they have a disparate and deleterious impact on the poor. Many women cannot afford to pay for the cost of unfunded medical services and the trip to a jurisdiction where they are available. Provincial and territorial funding decisions therefore have particular and prejudicial consequences for them. With the documented extent of the feminization of poverty, certain funding restrictions doubly disadvantage women: first, because they are women and second, because they are poor. The Badgley Report found that inequities in the distribution and accessibility of therapeutic abortion services hurt women who were less educated, women with lower incomes, and women who lived in smaller centres or rural areas.[127] Taking into account the relative powerlessness of the poor, a purposive approach to extending Charter protections to unenumerated groups supports their inclusion. In addition, because the primary aim of the *Canada Health Act* is to provide health services regardless of individual ability to pay, the burdens placed on the poor to carry the costs of their own medical care make a grouping around economic inability especially salient.

Limitations on reproductive health care also may have a negative and disparate impact on young women. Again the possibility of double discrimination is raised, although this time on the basis of the two enumerated grounds of age and sex. Unwanted teenage pregnancy may result when societal barriers reinforce legal ones. In addition, formal restrictions operate to the disadvantage of immigrant women who may be unfamiliar with Canada's institutions and languages.[128]

The strongest equality argument in this context is a sex equality argument. Under the wording of section 15, sex is an enumerated category of prohibited discrimination and is intended to attract particular attention. It is also extremely important to analyse controls on women's reproduction under equality guarantees because they have tended to be discussed solely in terms of individual rights and freedoms. In the United States, for example, the right to abortion is supported on the basis of an individual woman's privacy, not all women's equality. In Canada, the Supreme Court in *Morgentaler* was content to strike down section 251 of the *Criminal Code* on the basis that it infringed a woman's security of the person or liberty interest under section 7. The Court did not need to comment on the equality arguments made against section 251 and refrained from doing so. There remains a need to educate all decision-makers, including judges, on the equality implications of controls on women's reproduction because where pregnancy is part of the issue, some people are unable to see that sex equality is still possible, or indeed even relevant.[129]

There are many advantages to a sex equality analysis. Equality is essentially a contextual and comparative concept, whereas infringements of individual rights can often be discussed and resolved at fairly high levels of abstraction. Equality involves and requires a comparison within real life conditions. The focus is on the effects, consequences, and applications of a provision within its modern context. This is especially significant in relation to women's reproductive health where equality requires not just notionally similar rights but the actual provision of services. An equality analysis is consistent with international studies which indicate that the toll on the life and health of women caused by illegal abortion does not

significantly decline unless abortion services made lawful in theory are made available in practice.[130]

Therefore, an equality analysis requires that attention be paid to the actual life circumstances of women and collectively based interests as well as personal autonomy. It is the difference between saying that a woman has a right to control her own body, and that women, as a group, need access to abortion to have the equal opportunity to plan and control their lives. There is some overlap between individual and group rights in these cases because systemic discrimination is experienced by individuals and individual discrimination, when repeated, becomes systemic. Group rights to reproductive health care will also be measured in terms of their general availability and whether individual members of the group have access to them. Hence, to emphasize a collectively based equality argument is more shading than contrast but it reinforces that what happens to one woman is often a representative sample and not an isolated case.

An equality analysis may also help break down the public/private distinction in relation to constitutional rights, force us to question the impact of social constraints on women's choice, and undermine the idea that pregnancy is a universally and freely chosen state both for women as a group as well as for many individual women. In turn, this may encourage decision-makers to question how their policies operate on socially disadvantaged groups. The facial neutrality of a provision will become less important than the realization that everyone will not be benefitted or burdened by it in an equivalent manner. An equality analysis of reproductive rights can also be seen as a first phase of the rethinking of rights proposed by Justice Wilson in *Morgentaler*.[131] A shift to groups' rights may also help policy-makers focus their concerns.[132]

The comparative basis of the concept of equality has led some courts and commentators to reject an equality analysis of reproduction-related issues because the real biological differences between men and women are said to preclude any meaningful comparison. Until recently, the Supreme Court of Canada used equality concepts in a way which tended to penalize pregnant women for the ways in which they are not like men. But three recent Supreme Court cases illustrate that biological difference and women's ability to become pregnant will no longer be allowed to preclude a sex equality argument. The three cases of *Andrews*,[133] *Brooks*,[134] and *Janzen*[135] effectively, and at times expressly, overrule the much-criticized decision of *Bliss v. A.G. Canada*.[136]

The *Bliss* case dealt with the *Canadian Bill of Rights*[137] and the ability of a pregnant woman to obtain regular unemployment benefits under the *Unemployment Insurance Act*.[138] The Supreme Court held that the protections under the *Canadian Bill of Rights* did not apply to legislated benefits (in contrast with legislated penalties), that pregnancy discrimination was not sex discrimination, and that equality required a review of similarly situated individuals. Each of these conclusions has been changed or overruled.

Section 15 of the Charter clearly extends equality protections to legislated benefits as well as legislated burdens. Its wording was purposively selected to reverse this aspect of the *Bliss* case.[139] Any residual judicial reluctance to review

benefits with significant cost implications and/or to show them greater deference than legislated burdens can be expected to take place under section 1 or under the section 15 determination of whether there is discrimination. To the extent that benefits may continue to be treated any less rigorously, it is important to establish that the special treatment of certain reproductive health-care services is a burden imposed solely on women. Whether something constitutes a benefit or burden depends largely on perspective, upon whether the focus is on the person supposedly benefitted or allegedly burdened. If the analysis assumes women as the reference point, the different, exclusive and heavier qualifying requirements for women's medical services, given their overall health-care needs, are burdens imposed only on women. Just as a maternity ward in a hospital is not a special benefit to women, the withdrawing of funding for sterilizations can only operate as a financial and physical burden on women. Under the criteria of the *Canada Health Act*, no group is supposed to be burdened.

The second holding in *Bliss*, that pregnancy discrimination is not sex discrimination, has been expressly overruled in *Brooks v. Canada Safeway Ltd.*[140] In *Brooks*, the Supreme Court rejected the argument made in *Bliss* that any discrimination against pregnant women was not on the basis of sex, but resulted from the inherent biological differences between men and women.

In *Brooks*, the complainant challenged her employer's group insurance plan under the *Manitoba Human Rights Act*.[141] The employer's accident and sickness insurance insurance plan excluded coverage for pregnant women during a 17-week period surrounding the anticipated date of delivery. Because pregnant employees received significantly less favourable treatment under the plan than other employees, the Supreme Court had no difficulty concluding that the complete disentitlement of pregnant women during this period from receiving accident or sickness benefits was discrimination by reason of pregnancy. There was discrimination because the plan singled out pregnancy for disadvantageous treatment, in comparison with any other health reason which may prevent an employee from reporting to work. The Court reasoned that pregnancy was a valid health-related reason for absence from work and that to exclude it imposed unfair disadvantages on pregnant women. The Court explained how everyone in society benefits from procreation but that, under this insurance plan, the costs were unfairly placed on pregnant women. Because the removal of unfair disadvantages imposed on groups in society is a key purpose of anti-discrimination legislation, a finding that the respondent's plan was discriminatory was consistent with and furthered the purpose of the *Manitoba Human Rights Act*.

The Supreme Court then reversed the *Bliss* case and found that discrimination on the basis of pregnancy was discrimination on the basis of sex. Chief Justice Dickson commented upon the "profound changes in women's work force participation" where "[c]ombining paid work with motherhood and accommodating the childbearing needs of working women are ever-increasing imperatives".[142] The Court accepted that:

> The capacity for pregnancy is an immutable characteristic, or incident of gender and a central distinguishing feature between men and women. A distinction based on pregnancy is not merely a distinction between those who are and are not pregnant, but also between the gender that has the capacity for pregnancy and the gender which does not.[143]

The Court ruled that distinctions based on pregnancy can be nothing other than distinctions based on sex or, at least, strongly "sex related".

The Supreme Court also expressly cautioned that it is wrong to believe that pregnancy-related discrimination could not be sex discrimination because not all women become pregnant. While pregnancy-based discrimination only affects part of an identifiable group, it does not affect anyone who is not a member of the group. Indeed, pregnancy cannot be separated from gender. The fact, therefore, that the plan did not discriminate against all women, but only against pregnant women, did not make the impugned distinction any less discriminating. That discrimination against only some members of a class is still discrimination was reinforced by the Supreme Court's decision in *Janzen* which held that the sexual harassment of only some female employees was nevertheless sex discrimination.[144]

The Supreme Court, therefore, has recognized that the uniqueness of women's reproductive situation does not justify disadvantageous, hence unequal, treatment by law. The Court has reasserted that while laws cannot alter the inherent reproductive capacities of men and women, they can and do prescribe the social and legal consequences which attach to them. Biology may dictate that only women can become pregnant, but how the legislature treats pregnant women will be open to judicial scrutiny under the Charter. This is important because it is legislative powers, not the natural order, which regulate access to women's reproductive health-care services.[145]

Recognizing pregnancy discrimination as sex discrimination under the *Manitoba Human Rights Act* is a strong indication that pregnant women will now be within the constitutional protections of sex equality.[146] In *Andrews*,[147] Justice McIntyre said that the approach to discrimination in human rights legislation is relevant in the interpretation of Charter guarantees. This result is consistent with a purposive approach to Charter equality rights because men and women are most unequal when they are the most different.[148]

Under the similarly situate test used in *Bliss*, the real biological differences between men and women meant that there was no inequality; the absence of an analogous physical condition or equivalent life experience for men meant that there were not two similarly situated groups which could be compared to determine whether there was equal or unequal treatment. Maleness was the standard against which pregnant women were compared and, because the Court saw a real biological difference between men and women, they could be treated differently without there being any inequality. In *Andrews*, the Court expressly rejected the similarly situate test as being "seriously deficient" for equality comparisons under the Charter. Justice McIntyre said that a similarly situate test could lead to results akin to the *Bliss* case. The cumulative effect of these factors is to affirm the viability of a sex equality

analysis to matters of reproductive health, despite the reality of biological differences between men and women.[149]

Under the equality test enunciated by the Supreme Court in *Andrews*, certain provincial or territorial regulations on women's reproductive health are suspect. In *Andrews*, the Court required that "[c]onsideration must be given to the content of the law, to its purpose, and its impact upon those to whom it applies and also upon those whom it excludes from its application".[150] The purpose of section 15 is to ensure equality in the formulation and application of the law. This means that even a gender-neutral provision on reproduction, such as withdrawing funding from all sterilizations, will raise sex equality issues because, by definition and application, legal controls on human reproduction either directly or disparately affect the group which reproduces the species.

While the Supreme Court acknowledged that legislated burdens can be imposed and legislative distinctions made, it stated that they must, nevertheless, be imposed or made equally in accordance with section 15. Therefore, the discriminatory distribution through budget cuts of services and the selective regulation of women's health care may breach the equality standard enunciated in *Andrews* because the distinction would be prejudicial and disadvantageous to women. A breach of section 15 occurs when a differentiation undermines our fundamental values. This type of infringement occurs when women, and not men, are denied access to medically necessary services. The Court said: "[t]he promotion of equality entails the promotion of a society in which all are secure in the knowledge that they are recognized at law as human beings equally deserving of concern, respect and consideration".[151] Provincial or territorial regulations which impair access to medical services made necessary to women because of their reproductive capabilities do not treat women as equally deserving of regulatory or medical concern, do not respect their biological differences from men, and do not give their reproductive capacities equal consideration.

A complainant may also allege that full payment under the *Canada Health Act* in these circumstances by the federal government is inconsistent with the Charter. Because the *Canada Health Act*, like any federal statute, is subject to the Charter, it must be approached and applied in a manner consistent with the Charter's guarantees. Decisions concerning transfer payments taken under statutory power by the federal Cabinet raise justiciable issues. A complainant could argue that by making full payment to provinces in breach of the criteria of comprehensiveness, accessibility, and universality, the federal government is discriminating against women on the basis of their sex, residence, or socio-economic status. Women who pay federal taxes and provincial/territorial insurance premiums are not receiving the promised level of health service they need because certain provincial or territorial regulations have singled out women-specific medical procedures for less advantageous treatment.

When applying the sex equality guarantees to women's reproductive health care, the provision and entitlement to medical services must be measured in light of the court's acknowledgement that section 15 has a large remedial focus. Taken together, the legislative history and text of sections 15 and 28 of the Charter disclose

an intent to promote the equality of women. Section 15 explicitly recognizes, especially in subsection 2, that amelioration of disadvantage is an integral part of the equality guarantee. Many of the present-day disadvantages of women arose in association with their capacity for and role in childbearing, and the restrictions placed on women because of a narrow view of their "biological destiny".

These cases open the door to the type of equality arguments proposed by Professor MacKinnon[152] and the Women's Legal Education and Action Fund (LEAF).[153] Neither approach requires similarly situated groups. Professor MacKinnon seeks to address the core issue of inequality by asking whether the challenged policy or practice contributes to the oppression of women. The disadvantageous and prejudicial treatment of women because they are women would be unequal even if there was no one or nothing to compare them with. LEAF has presented a detailed sex equality argument, on matters relating to women's reproductive capacities and the legal right to an abortion, to the Supreme Court of Canada. LEAF argued that while pregnancy may be a voluntary condition in the case of some individual women, for women as a group pregnancy is not voluntary. For women to bear children is an obvious social imperative.

Both approaches emphasize that the social context of sex inequality has denied women control over the reproductive uses of their bodies in ways that have not been true for men. First, they point to how women have been socially disadvantaged in controlling sexual access to their bodies because of social learning, lack of information, inadequate or unsafe contraceptive technology, social pressure, custom, poverty and enforced economic dependence, sexual force, and ineffective enforcement of laws against sexual assault. As a result, they often do not control the conditions under which they become pregnant.[154]

Second, they explain that under conditions of social inequality on the basis of sex, women have been allocated primary responsibility for the intimate care of children. Social custom, pressure, economic circumstances, and lack of adequate child care (public or private) have meant that women often do not control the circumstances under which they rear children. Men as a group are not comparably disempowered by their reproductive capacities and are not generally required by society to spend their lives caring for children to the comparative preclusion of other life pursuits.[155]

Women's reproductive capacity is seen as an integral part of women's "equality problem", along a spectrum of situations. Whether or not they actually have children, all women are disadvantaged by societal norms that limit their options in the public domain because of childbearing and childrearing.[156] Women who become pregnant and have children face additional burdens because of their roles outside the family, because of custom, and because society's resources are not usually allocated in a way that would assist women's childbearing and childrearing activities. These circumscriptions affect even those women whose pregnancies and childrearing are voluntary.[157] This inequality has important implications for the interpretation of the Charter's equality guarantees. LEAF urges that for women of reproductive age, the guarantee of sex equality should be interpreted so as to reduce or minimize state-sanctioned interference with women's full development as legal

persons, socially, economically, and politically.[158] For women who are pregnant, and carrying the fetus to term, regard for sex equality should prohibit state-sanctioned interference with their physical being and their authority to make prenatal care-taking decisions. LEAF also argues that women's equality rights should preclude the kind of state coercion into motherhood which results when the state bars or controls women's access to abortion.[159] Access to reproductive health care, including abortion, is seen as a necessary means for women to survive in their unequal life circumstances. Women's access to legal abortion is viewed as an attempt to ensure that women and men have more equal control of their reproductive capacities, more equal opportunity to plan their lives, and more equal ability to participate fully in society than if legal abortion did not exist.[160,161]

The guarantees in sections 15 and 28 require that the Charter must provide women faced with unwanted pregnancies a secure right to control the number, timing, and spacing of their children. Other controls on access to women-specific medical services could deprive women of sex equality if the deprivation of reproductive control would prolong women's historical relegation to social subordination and second-class citizenship, where all direct victims of deprivation of reproductive control would be female or where women's self-determination and autonomy would be burdened by law in a way that men's are not.[162]

Section 1 and Justifiable Limits on Charter Rights

If a Charter section (such as sections 7, 15, or 28) is breached, under section 1 the burden would then shift to the government which would attempt to establish that the infringement of the protected right is nevertheless reasonably justified in a free and democratic society. Under the *Oakes*[163] test, the first inquiry is whether the government objective relates to concerns which are pressing and substantial in a free and democratic society. The second inquiry involves a proportionality test. In *Andrews*, Justice McIntyre suggested that the first aspect of the *Oakes* test is too stringent when applied to breaches of the equality guarantees. He would alter the standard requirement that the state interest must be pressing and substantial and replace it with the less onerous test of whether the government can establish a desirable social objective. The majority of the Supreme Court did not, however, endorse this lower level of judicial scrutiny in the case of a breach of section 15. The Court therefore split on both the interpretation and application of section 1. Under the majority judgement of Justice Wilson, the government will still be required to demonstrate a pressing and substantial state interest, regardless of whether the breach of the infringed right occurred under section 7 or section 15. This is an important point because a lower level of judicial scrutiny for equality infringements may impair the evolution of equality theories and discourage the use of equality arguments.

A government attempting to establish its pressing and substantial interest in reproductive health care can be expected to argue that it must protect the safety of women patients in women-specific procedures, ensure the efficient allocation of medical resources, and perhaps claim that it has an interest in protecting fetal life

where there is a potential woman-fetus conflict. Under section 1, a court would evaluate the propriety of the legislative goal proposed and then assess the proportionality of the means used to attain those ends.

For example, under section 1 the court could be expected to scrutinize a provincial/territorial regulation requiring abortions to be performed in hospitals. It would ask whether abortions in hospitals are safe or safer — in the same manner as the Supreme Court questioned the proportionality of mandating that therapeutic abortions could only be performed in approved or accredited hospitals. The available facts and the evidence are very significant on this type of legal question. In this respect, the experience of some provinces with alternative facilities, such as reproductive health clinics, may be helpful in comparing the safety and efficiency of various facilities. It has been claimed that special reproductive health-care clinics resolve many of the problems associated with reproductive health services provided in hospitals.[164] When abortions are required to be performed in hospitals, operating rooms must be allocated, and health-care workers may be unsympathetic to the pregnant woman. Clinics save time and money and often offer safer procedures than those available in hospitals.[165] Clinics can offer specialization in reproduction-related matters and greater follow-up capabilities. The workers drawn to such a clinical setting tend to be more sympathetic to pregnant women; as well, employers or operators would not expect to experience the dilemma raised by employees who are conscientious objectors.[166] Fewer delays usually result because there is not the same problem of allocating and scheduling operating time and booking the anesthesiologists required in the hospital setting.

The differential regulation of abortion compared with similar procedures must be closely scrutinized to determine whether it stands as a barrier to access which cannot be justified on the basis of sound medical judgement. The fact that a first-trimester abortion performed by a competent medical practitioner is a relatively safe and simple medical procedure suggests that it should be treated like other similar medical procedures. Therefore, the courts will question whether the special rules which have emerged to replace the legally defunct therapeutic abortion committees serve any recognized provincial/territorial interest. For example, a hospital policy or provincial or territorial requirement that all abortions must be performed by a specialist in gynecology or obstetrics may fail to take into account that early abortions are medically safer than childbirth. While different regulations may be warranted for late-term abortions (which require more skill, technology, and facilities), based on the health needs of women, there is no medical reason to support such a policy or regulation for early abortions. In fact, Professors Cook and Dickens suggest that it may be appropriate in certain circumstances to allow trained staff who are not doctors to perform the abortion, with the doctor assuming ultimate responsibility for the procedure.[167] The differential regulation of abortion compared with similar procedures must be closely scrutinized to determine whether it stands as a barrier to access which cannot be justified on the basis of sound medical judgement.

The court may also question whether budgetary restraints are properly allocated by reducing services rather than pursuing alternative possibilities which do not infringe Charter principles or breach *Canada Health Act* provisions. Consistency may also be a key factor. The justification of fiscal exigencies may become suspect if it can

be shown that budgetary restrictions are allocated disproportionately, or are targeted against specific services where there appears to be a systematic provincial or territorial policy against that particular reproductive health service, or where services could be provided in a more cost-effective manner in alternative facilities. Even if the legislation at issue is held not to comply with the requirements of the Charter, the provincial/territorial government may still raise a claim of jurisdiction over the protection of fetal life where there is a potential woman-fetus conflict.

In assessing the province's interest in protecting fetal life, an important but unresolved issue is whether the fetus has independent Charter rights which must be considered when any issue of post-conception reproductive health care arises. Under present law, personhood vests at birth.[168] Until the Supreme Court of Canada decides whether a fetus has constitutional rights, this remains an unknown factor.[169] But for the Supreme Court to confer Charter rights on the fetus would be an unprecedented departure from previous Canadian cases, and it also would be inconsistent with the law of the vast majority of countries, including England and the United States, to which Canada most often turns for comparative law purposes. A conferral of constitutional rights on the fetus by the judiciary would appear to be a manufacturing of new rights from whole cloth; an endeavour in which the Supreme Court has often said it will not engage, and one which would open the Court up to the criticism that it was exceeding its legitimate authority by acting as a legislature.

Conferring constitutional rights on the unborn would be novel and have far-reaching implications concerning such diverse and morally complex matters as the use of IUDs, abortion, prenatal abuse, reproductive technologies, and coerced medical treatment of pregnant women. In addition, the Supreme Court has already outlined a way in which the interests of the fetus can be protected under the Charter without creating new rights. In the *Morgentaler* decision, the Court held that the state had a legitimate interest in protection of the fetus which could be asserted when the government is called upon to prove that one of its actions which infringes a Charter right is demonstrably justifiable in a free and democratic society. This approach may illustrate a preference for treating the legal status of the fetus as a question of a public "interest" rather than granting separate and independent Charter "rights" to the fetus.

In *Morgentaler*, the Supreme Court recognized that Parliament has a legitimate interest in the protection of fetal interests. This raises the issue of whether provincial and territorial legislatures have any interest in the protection of the fetus. As any state interest asserted under section 1 must be circumscribed by the constitutional division of powers, the recognition of a Parliamentary jurisdiction to protect fetal interests does not vest an equivalent jurisdiction in the provinces and territories and it may even preclude it. Therefore, a province or territory cannot rely upon the analysis or dicta in *Morgentaler* to establish its state interest in the fetus — it must justify restrictions on women's Charter rights and base its claim to speak for the fetus on its jurisdiction over civil rights within the province or territory.

The extent of any such alleged state interest may also be problematic. For example, is the interest limited to the fetus at any given time or does it extend to a state interest in future populations such that curtailment of women's Charter rights can be justified not only during pregnancy but throughout a woman's childbearing years?

When reviewing what occurs in other free and democratic societies, the worldwide changes in the legal regulation of abortion should be noted.[170] Increasingly, such legislation de-emphasizes criminality and the focus is on abortion as an integral part of a country's health and social welfare programs. Governments have begun to recognize that the desire for a coherent position promoting the state's interest in health and family life requires more than creating abortion-related offences. Such a position also involves:

- widespread access to and public funding of birth control counselling;
- the prohibition of pregnancy-based discrimination;
- generous maternity leave benefits;
- reasonably priced child care; and
- an improvement in the life circumstances of children, women, and families.

Some countries acknowledge that to the extent that the state proscribes abortion, and forces women to sacrifice their own priorities and aspirations, it must also assume the concomitant obligation of establishing and paying for adequate supporting social services. Otherwise, women are even more obviously and unfairly burdened by the state's interference with their reproductive control. The provision of adequate supporting services is also seen as the necessary precondition to create the social and economic environment in which a pregnant woman has a true choice between realistic alternatives.

Conclusion

One of the most problematic forms of control over women's reproductive health is the absence of access to medically necessary services. Since the criminal law prohibition against abortion was invalidated in the *Morgentaler* decision, the significance of the provincial or territorial jurisdiction to regulate the practice of medicine and the availability of health-care services has emerged. Provincial or territorial powers have been used in a variety of ways to effect different policies on reproductive health generally, and abortion in particular. Provinces or territories which have expanded the range of medical options available to a woman seeking to control her reproductive capabilities run little risk of breaching the *Canada Health Act* or infringing women's Charter rights.

Provinces restricting access to medically necessary services are at a much greater risk of non-compliance with both. Decisions by provinces/territories to restrict access or funding and to enact special and limiting regulations may, therefore, be challenged in the courts. Numerous difficult legal questions are raised by the scope

of review, the remedies available, and the parties against whom the remedies are available. It is clear that the promise of comprehensive, accessible, and universal medical services and the constitutional right to life, liberty and security of the person as well as the equal benefit and protection of the law mean that women have a legal basis on which to promote their claim to adequate health services which incorporate their childbearing capacities. When the issue is the legality of controls on women's reproductive rights, the *Canada Health Act* and the Charter should be the starting point for initiating any legal action, proposing legislation, or promoting social change.

Endnotes

1. Louise Lapierre, *Canadian Women: Profile of Their Health* (Ottawa: Statistics Canada, April 1984), p. 30.
2. *Ibid.*
3. *Canada Health Act*, S.C. 1984, c. 6 [also the Act].
4. Part I of the *Constitution Act, 1982*, being Schedule B of the *Canada Act 1982* (U.K.), 1982, c. 11 [hereinafter Charter].
5. *Andrews v. Law Society of British Columbia* (1989), 91 N.R. 255 at 260 (S.C.C.) [hereinafter *Andrews*].
6. For an overview of the position of women in Canada, see: N. Colleen Sheppard, "Equality, Ideology and Oppression: Women and the *Canadian Charter of Rights and Freedoms*" (1986) 10 *Dalhousie L.J.* 2:195-223; and Mary Eberts, "Sex-based Discrimination and the *Charter*" in Anne F. Bayefsky and Mary Eberts, eds., *Equality Rights and the Canadian Charter of Rights and Freedoms* (Toronto: Carswell, 1985), pp. 183-229.
7. *R. v. Morgentaler* (1988), 82 N.R. 1 at 125 (S.C.C.) [hereinafter *Morgentaler*].
8. *Constitution Act, 1867* (U.K.), 30 and 31 Vict., c. 3 (formerly *British North America Act, 1867*).
9. Peter W. Hogg, *Constitutional Law of Canada*, 2nd ed. (Toronto: Carswell, 1985), p. 405.
10. 1982, [1982] 2 S.C.R. 112 at 141.
11. Dale Gibson, "Measuring National Dimensions" (1976) 7 *Man. L.J.* 15. Using these principles, an argument can be made that the federal government has the power to address the regulatory health aspects of abortion because it has become a matter of "national concern or dimension" as defined in *R. v. Crown Zellerbach Canada Ltd.* (1988), [1988] 1 S.C.R. 401 at 431-434. Arguably, the inequality of access to abortion from province/territory to province/territory and within provinces/territories, as outlined in the Badgley Report [Canada, Committee on the Operation of the Abortion Law, *Report of the Committee on the Operation of the Abortion Law* (Ottawa: 1977)], the Powell Report [Marion Powell, *Report on Therapeutic Abortion Services in Ontario: A Study Commissioned by the Ministry of Health* (Toronto: Ministry of Health, 1987)], and in the judgements of the Chief Justice and Justice Beetz in *Morgentaler, supra*, note 7, has created a problem of national dimension for women. After *Morgentaler*, the disparate regulation of abortion services exacerbates this inequality and illustrates the unfairness which results in the absence of a national standard. This is a "new" problem in the sense that its national dimensions and far-reaching implications have only become publicly known recently. Abortion is a single, distinctive, and indivisible topic. Allowing federal regulation of abortion services would not overwhelm or unduly restrict provincial and territorial powers over health, medicine, and hospitals. In addition, the failure of one province or territory to provide access to lawful abortion services may increase the demand for such services in other provinces or territories, thus placing an institutional burden on the systems and structures of the guest jurisdiction (which is probably only tailored to meet the needs of its population) and a personal burden on those women forced to journey from their home province or territory. In short, there are public policy and legal justifications for a national regime even though the cases in which the Supreme Court has used the national dimension branch to support legislation have dealt with very different types of problems.

12. R.S.C. 1970, c. F-27.

13. For cases dealing with federal powers over health, see generally: *R. v. Wetmore* (1983), [1983] 2 S.C.R. 284; *Labatt Breweries of Canada Ltd. v. A.G. Canada* (1979), [1980] 1 S.C.R. 914; *R. v. Hauser* (1979), [1979] 1 S.C.R. 984. For a general discussion of jurisdictional issues, see: Andrée Lajoie and Patrick A. Molinari, "Partage constitutionnel des compétences en matière de santé au Canada" (1978) 56 *Can. Bar. Rev.* 579; R.T. McKall, "Constitutional Jurisdiction Over Public Health" (1975) 2 *Man. L.J.* 317. A few other statements declare that the performance of abortion is a provincial and territorial matter, subject to the criminal law provisions. See also: *Carruthers v. Therapeutic Abortion Committees* (1983), 6 D.L.R. (4th) 57.

14. *Criminal Code*, S.C. (1953-54), c. 51, s. 150.(2)(c), (d). See generally: Constance B. Backhouse, "Involuntary Motherhood: Abortion, Birth Control and the Law in Nineteenth Century Canada" (1983) *Windsor Yearbook of Access to Justice* 3 at 61; Shelley A.M. Gavigan, "On Bringing on the Menses: The Criminal Liability of Women and the Therapeutic Exception in Canadian Abortion Law" (1986) 1 *Can. J.W.L.* 279.

15. R.S.C. 1970, c. C-34.

16. *Morgentaler, supra*, note 7.

17. *Criminal Code, supra*, note 15. Section 206 includes as homicide the killing of a child when it has completely proceeded, in a living state, from the body of its mother; ss. 216 and 220 set out the offence of infanticide which concerns the death of a "newly-born child"; s. 221 establishes the offence of killing an unborn child in the act of birth; s. 226 makes it an offence to neglect to obtain assistance in childbirth; s. 227 contains a prohibition against concealing the body of a child; and ss. 205 et. seq. set out the general articles on the murder and manslaughter of "persons".

18. *Supra*, note 15.

19. See John E.B. Myers, "Abuse and Neglect of the Unborn: Can the State Intervene?" (1984), 23 *Duq L. Rev.* 1 at 76; Jeffry A. Parness, "Crimes Against the Unborn: Protecting and Respecting the Potentiality of Human Life" (1985), 22 *Harv. J. on Legis.* 97 at 171-172; Note, "Maternal Substance Abuse: The Need to Provide Legal Protection for the Fetus" (1987), 60 *S. Cal. L. Rev.* 1209 at 1235.

20. Law Reform Commission of Canada, *Crimes Against the Foetus*, Working Paper 58 (Ottawa: 1989), pp. 63-65. Although the Commission states it only intends to criminalize intentional maternal injury to the fetus, the wording of the section is much broader than they contend.

21. *Supra*, note 15. See: "Woman [Pamela Stewart] Facing Criminal Charges Over Her Conduct In Pregnancy", *New York Times*, 9 October 1986 at A-22, col. 1. Ms. Stewart was charged under *California Penal Code* 270. The statute provides in relevant part:

> If a parent of a minor child willfully omits, without lawful excuse, to furnish necessary clothing, food, shelter or medical attendance, or other remedial care for his or her child, he or she is guilty of a misdemeanor.

People v. Pamela Rae Stewart, (26 February 1987) Calif. Crim. Docket No. M-508187 (Calif. Mun. Ct.), p. 14; *California Penal Code* 270 (West 1970 and Supp. 1988).

22. *R. v. Sullivan* (1988), 31 B.C.L.R. (2d) 145 (B.C.C.A.); *Criminal Code, supra*, note 15, s. 2 "person".

23. *Re Baby R.* (1988), 15 R.F.L. (3d) 225 (B.C.S.C.) rev'g (1987), 9 R.F.L. (3d) 415 (B.C. Prov. Ct.); *Family and Child Service Act*, S.B.C. 1980, c. 11, s. 1 "child".

24. For the case against criminalization, see: Note, "Maternal Rights and Fetal Wrongs: The Case Against the Criminalization of Fetal Abuse" (1988), 101 *Harv. L. Rev.* 994; Rebecca Manson and Judy Marolt, "A New Crime: Fetal Neglect: State Intervention to Protect the Unborn — Protection at What Cost?" (1988), 24 *Cal. West. Law Rev.* 161.

25. *Supra*, note 8; Peter Hogg, *supra*, note 9, p. 124.

26. *Federal-Provincial Fiscal Arrangements and Federal Post-Secondary Education and Health Contributions Act*, R.S.C. 1985, c. F-8.

27. *Supra*, note 8, ss. 92(7) gives provinces this authority. The Territories are granted identical authority through the enactment of the *Yukon Act*, R.S.C. 1985, c. Y-2, s. 17(g), (h) and the *Northwest Territories Act*, R.S.C. 1985, c. N-27, s. 16.

Pursuant to the *Interpretation Act*, R.S.C. 1985, c. I-21, s. 35(1), "province" refers to a province of Canada and includes the Yukon Territory and Northwest Territories. Section 8(1) states that every federal enactment applies to the whole of Canada, unless a contrary intention is expressed in the enactment. The *Canada Health Act* does not contain any provision excluding its application from the territorial governments. Nevertheless, the unique relationship and financial dependency of the Territories to the federal government makes it difficult to apply with certainty all the comments in this report regarding the *Canada Health Act*, especially its remedial provisions.

The federal government took responsibility for the delivery of health services to the Territories in 1954.

In 1982, the federal and Northwest Territories governments agreed to a transfer of the responsibility of some health services to the Territories. As of 20 April 1988, the two governments effected an agreement transferring to the Territories responsibility for general hospitals in Fort Simpson and Inuvik as well as public health services provided throughout the community nursing stations and health centres. (See: "N.W.T. Health Care Agreement", *Ottawa Letter*, vol. XVIII, no. 43, p. 345, 26 October 1987.)

The Northwest Territories receive the matching portions of their health-care costs pursuant to the *Canada Health Act*. Because the Territories has a small tax base, the majority of their other operational income is provided by the federal government (and this should include the other portions of their health-care costs). *Quaere*, if the Northwest Territories fail to satisfy the criteria prescribed under the *Canada Health Act* and the federal government chooses to withhold health-care funds, in whole or in part, could the Territories respond by requesting more operational funding, which in turn is applied to health care, but continue to avoid satisfying the criteria under the Act? If so, the remedial provisions of the Act would be rendered ineffective.

The federal government and the Yukon Territory are in the process of negotiating similar transfer arrangements to those made with the Northwest Territories. In the meantime, the federal government has responsibility for providing delivery of all health-care services. Health and Welfare Canada bills the Yukon Territory for the cost of such services, and the Territory pays this out of the Consolidated Revenue Fund which originates in large part from the federal government.

Under this arrangement, any failure to satisfy the criteria of the *Canada Health Act* lies with the federal government. *Quaere*, does the Yukon Territory have authority to withhold payment, in whole or in part, from the federal government if the *Canada Health Act* criteria are not met?

These issues are complicated by the existence of an unresolved dispute as to whether the federal government has constitutional jurisdiction over health care, or, in the case of the Yukon Territory, if it is just providing the service on behalf of the Territory.

28. *Reference Re Freedom of Informed Choice (Abortions) Act* (1985), 25 D.L.R. (4th) 751 (Sask. C.A.).

29. The absence of federal legislation means the field is no longer "occupied".

30. In *Planned Parenthood v. Danforth*, 428 U.S. 52 (1976), the United States Supreme Court struck down a Missouri abortion law which required the spouse's consent to any abortion to be performed within the first twelve weeks of pregnancy, unless the abortion was to preserve the mother's life.

31. See: Sheilah L. Martin, "Using the Courts to Stop Abortion By Injunction: A Case Comment on *Mock v. Brandenburg*", *Can. J.W.L.* (forthcoming).

32. On 28 January 1989 at p. A-13, *The Globe and Mail* gave the following overview of the situation in the provinces and territories. The current state of access across Canada is:

Newfoundland: The one hospital that performs abortions requires that women seeking the procedure be counselled by a psychiatrist, a gynecologist, a social worker, and a registered nurse. Abortions are done only in the first 12 weeks of pregnancy, and a doctor must confirm that it is "medically necessary". Only one doctor at St. John's General Hospital performs the procedure.

New Brunswick: A woman must obtain the approval of two doctors, who allow the abortions if termination of the pregnancy is "medically required". The procedure must be performed by a gynecologist in one of the province's four accredited hospitals, and women must meet certain geographic restrictions. The government has said it will not tolerate private clinics.

Nova Scotia: A woman may call one of 12 hospitals in the province that perform abortions and make an appointment. All the hospitals have strict quotas, and 85 per cent of abortions are done at Victoria General Hospital in Halifax, which has a limit of 35 a week. Dr. Henry Morgentaler has said he will open a clinic in Halifax within six months, but the government has vowed to fight its establishment.

Prince Edward Island: No legal abortions have been performed in the province since 1982. Out-of-province abortions are paid for by the province only if women obtain the approval of a committee of five doctors and an explanation of why termination is required. The province will not pay for abortions performed in clinics.

Quebec: This province offers the easiest access, with a handful of private clinics, a dozen community health centres, and 40 hospitals offering the procedure. Abortion is fully paid for except at private clinics, where partial payment is made. Access has been limited in outlying areas because some hospitals, after disbanding their therapeutic abortion committees, stopped doing abortions.

Ontario: Since the *Morgentaler* decision, the government has agreed to pay the full cost of abortions performed in hospitals and doctors' fees for clinic abortions. A third private clinic has opened in Toronto, and the province has introduced a bill to fully finance some private clinics. Access is limited outside Toronto, where many hospitals refuse to perform abortions.

Manitoba: The Morgentaler clinic in Winnipeg reopened after the *Morgentaler* decision, but the provincial government has refused to pay for clinic abortions. Access is limited outside the capital, and 90 per cent of abortions are

performed at the Winnipeg Health Sciences Centre.

Saskatchewan: A woman requires a referral from a doctor and either a second doctor or an approved form of counselling. Abortions are permitted only if considered a "medical necessity". There are geographic requirements in most of the province, and gynecologists in Regina refuse to perform abortions because the medicare rate is too low.

Alberta: The provincial government pays for abortions performed in hospitals if the patient has the approval of two doctors. Access is poor in Edmonton and northern Alberta.

British Columbia: The government moved to cut public financing for abortions, but that law was struck down by the B.C. Supreme Court. The province now pays the doctor's fee for all abortions, including those performed in private clinics. The government has launched a $20 million pro-family, anti-abortion education campaign. A new private clinic has opened in Vancouver.

Yukon: Abortions are performed at Whitehorse General Hospital. The government pays for the procedure and travel costs to the capital.

Northwest Territories: The government pays for abortions and for travel costs.

33. *Supra*, note 11.

34. *Supra*, note 11. See also: Luce Harnois, *Rapport de recherche sur l'avortement au Québec* (Montreal: Regroupement des centres de santé des femmes du Québec, 1987).

35. Each province has its own health care insurance plan.

36. Press Release, Alberta Department of Hospitals and Medical Care, 19 May 1987. The announcement was ambiguous because it claimed to be withdrawing funds from non-medically necessary services. These services were *prima facie* uninsured but there was an exception of "unless medically required". After stating that IUD insertions, including follow-up visits, were excluded, the government explained:

> There may be some situations where a woman with serious illness, e.g., diabetes or heart disease is unable to tolerate birth control pills. Under these circumstances insertion of an intra-uterine device would be insured.

37. *B.C. Civil Liberties Assn. v. B.C. (A.G.)* (1988), 24 B.C.L.R. (2d) 189 (B.C.S.C.).

38. Robert Walker, "Eight Women Caught in Abortion-Fee Battle", *Calgary Herald*, 14 February 1989, p. B-1. The physicians are protesting because the province no longer pays for a follow-up medical procedure which is necessary in many cases involving second-trimester abortions. The Alberta Medical Association's new policy provides that if another procedure is medically necessary within 24 hours after an abortion, no "extra" payment will be made. See also: *supra*, note 32, regarding the situation in Regina.

39. *Children's Act*, S.Y.T. 1984, c. 2, ss. 134(1).

40. See: *Joe v. Y.T. (Dir. of Fam. & Children's Services)* (1986), 5 B.C.L.R. (2d) 267 (Y.T.S.C.) for a preliminary case. Note that s. 1 of the *Family Services Act*, S.N.B. 1980, c. F-2.2 defines "child" to include an "unborn child". That Act does not contain a provision allowing supervision of a pregnant woman to safeguard the condition of the fetus as found in the Yukon statute.

41. This includes labour laws which govern pregnant women's exposure to work-place hazards.

42. In these cases, courts have found that the child was born having been abused. *Re Superintendent of Family and Child Service and McDonald* (1982), 135 D.L.R. (3d) 330 (B.C.S.C.); *Re Children's Aid Society for the District of Kenora and J.L.* (1981), 134 D.L.R. (3d) 249 (Ont. Prov.

Ct.); *Supt. of Family and Child Service v. M.(B.)* (1982), 28 R.F.L. (2d) 278 (B.C.S.C.).

43. *Supra*, note 23.

44. *Ibid.* at 237.

45. In *Re Children's Aid Society of City of Belleville and T.* (1987), 59 O.R. (2d) 204 (Ont. Prov. Ct.).

46. For a good overview, see: Kate Hughes, *Midwifery in Canada* (Ottawa: National Association of Women and the Law, 1985); Alberta Advisory Council on Women's Issues, *Midwifery in Alberta: A Discussion Paper* (Edmonton: 12 May 1988); Manitoba Advisory Council on the Status of Women, *Midwifery: A Discussion Paper* (Winnipeg: May 1987); Manitoba Advisory Council on the Status of Women, *Midwifery: Recommendations to the Manitoba Government* (Winnipeg: September 1988).

47. The most extensive review was conducted in Ontario. See: Ontario Law Reform Commission, *Report on Human Artificial Reproduction and Related Matters*, 2 volumes (Toronto: Ministry of the Attorney General for Ontario, 1985). Other provinces, such as Saskatchewan, have merely studied one aspect of the technologies. See: Law Reform Commission of Saskatchewan, *Proposals for a Human Artificial Insemination Act: Report to the Minister of Justice* (Saskatoon: March 1987).

48. For an excellent overview of the issues from a Canadian perspective, see the compilation of papers in: Conseil du statut de la femme, *Sortir la maternité du laboratoire: actes du forum international sur les nouvelles technologies de la reproduction organisé par le Conseil du statut de la femme et tenu à Montréal les 29, 30 et 31 octobre 1987, à l'Université Concordia* (Quebec: 1988).

    [Editor's note: In the Throne Speech on 3 April 1989, the federal government stated that it would "mandate a royal commission to inquire into the implications of new reproductive technologies for Canadian society." However, at the time of writing, no persons have been appointed to the proposed royal commission, no terms of reference have been established, and no date of commencement has been announced.]

49. On 4 February 1988, Frank MacDonald, chair of P.E.I.'s largest hospital (the Queen Elizabeth Hospital in Charlottetown) announced at a press conference that the hospital would not grant any physician privileges to perform abortions. This was confirmed by a full hospital Board Meeting on 23 February 1988. On 17 February 1988, the Board of the other main hospital (Prince Country Hospital in Summerside) announced a similar policy.

    In contrast, a British Columbia report stated that the accessibility of necessary health-care services was said to be a matter of social justice. In *Health Security for British Columbians: Special Report Health Care Problems of Women* (1974), at p. 11, the following question was posed:

    > Can we permit any publicly funded institution to refuse to offer these procedures on the grounds that a minority will not choose to require them or that they are proscribed by the religious belief of those who, by accident of history, retain control of the Hospital Board?

50. See: W.J. Harris and L.S. Tupper, "A Study of Therapeutic Abortion Committees in British Columbia" (1977), 11 *U.B.C.L. Rev.* 81. The authors explained that many women become discouraged at this initial stage if their own doctors do not support their decision to seek therapeutic abortions.

51. Powell Report, *supra*, note 11.

52. Ellen Picard, "Women and Medical Malpractice" in Sheilah L. Martin and Kathleen E. Mahoney, eds., *Equality and Judicial Neutrality* (Toronto: Carswell, 1987) at 248.

53. *Zimmer v. Ringrose* (1981), 28 A.R. 69 (Alta. C.A.). Leave to appeal to S.C.C. refused.

54. For example, *Fredette v. Wiebe* (1986), 37 C.C.L.T. 106 (B.C.S.C.).

55. *Buchan v. Ortho Pharmaceutical (Canada) Ltd.* (1986), 35 C.C.L.T. (Ont. C.A.).

56. *Supra*, note 3.

57. For a general discussion, see: Monique Bégin, *Medicare: Canada's Right to Health* (Montreal: Optimum Publishing International (1984) Inc., 1988).

58. "Health Charter for Canadians" in Emmett M. Hall, *Royal Commission on Health Services*, vol. 1, pp. 11-12 (Ottawa: Queen's Printer, 1964) [hereinafter *Health Charter*].

59. *Supra*, note 3.

60. *Ibid.*

61. *Ibid.*, s. 2.

62. *Supra*, note 58.

63. Canada, *Royal Commission on Health Services* (Hall Report), 2 volumes (Ottawa: Queen's Printer, 1964-1965).

64. *Supra*, note 58, p. 11.

65. Emmett M. Hall, *Canada's National-Provincial Health Program for the 1980's* (Ottawa: Health and Welfare Canada, 1980) at 41.

66. *Webster's Third New International Dictionary of the English Language Unabridged* (Springfield, Mass.: Merriam-Webster Inc., 1986), p. 2498, col. 3.

67. Gwen Brodsky and Shelagh Day, *Canadian Charter Equality Rights for Women: One Step Forward or Two Steps Back?* (Ottawa: Canadian Advisory Council on the Status of Women, 1989).

68. *R. v. Big M Drug Mart Ltd.*, [1985] 1 S.C.R. 295; *Andrews*, *supra*, note 5.

69. *Supra*, note 63 at 41 et seq.

70. *Supra*, note 7.

71. *Journal of the Legislative Assembly of the Province of Prince Edward Island* at 90-91, 117-118 (1988).

72. *Supra*, note 58 at 11.

73. *Supra*, note 63.

74. See: Leslie A. Pal, *The Canada Health Act (1984) and Beyond* (Calgary: University of Calgary, Research Unit on Public Policy, May 1984) at 19.

75. Hogg, *supra*, note 9, p. 123 et seq.

76. The *Canada Health Act* is mentioned in *Sask. Medical Association v. Medical Comp. Review Board (Sask.)* (1987), 62 Sask. R. 179 (Sask. Q.B.); *Winterhaven Stables Ltd. v. Canada (A.G.)* (1986), 71 A.R. 1 (Alta. Q.B.).

77. In this case, the source of the government's decision must be scrutinized to ascertain whether an administrative law claim is available. Different jurisdictions have different methods of regulating recoverable fees. For example, see: *Health Services and Insurance Act*, S.N.S. 1973, c. 8; *Newfoundland Medical Care Insurance Act*, R.S. Nfld. 1970, c. 265; *Health Insurance Act*, S.O. 1980, c. 197; *Health Services Insurance Act*, R.S.M. 1987, c. H-35; *The Saskatchewan Medical Care Insurance Act*, R.S. Sask. 1978, c. S-29; *Alberta Health Care Insurance Act*, R.S.A. 1980, c. A-24; *Hospital Insurance Act*, R.S.B.C. 1979, c. 180; *Health Services Payment Act*, R.S.P.E.I. 1974, c. H-2; *Hospital Services Act*, R.S.N.B. 1973, c. H-9, *Medical Services Payment Act*, R.S.N.B. 1973, c. M-7, *Health Services Act*, R.S.N.B. 1973, c. H-3; *Territorial Hospital Insurance Services Ordinance*, R.O.N.W.T. 1959 (2nd), c. 3; *Health Care Insurance Plan Act*, R.S.Y. 1986, c. 81, *Hospital Insurance Services Act*, R.S.Y. 1986, c. 85; *Health Insurance Act*, R.S.Q. 1977, c. A-29.

78. *B.C. Civil Liberties Assn. v. B.C. (A.G.)*, *supra*, note 37.

79. *Morgentaler v. A.G. New Brunswick*, [1989] N.B.J. No. 311; (13 April 1989), N.B.Q.B. F/M/103/88.

80. *Ibid.* at 6.

81. *Finlay v. Can. (Minister of Finance)* (1986), [1987] 1 W.W.R. 603 (S.C.C.). For a comment, see: T.A. Cromwell, "From Trilogy to Quartet: Minister of Finance of Canada v. Finlay" (1987) 7 *Windsor Yearbook of Access to Justice* 103.

82. *Finlay v. Canada (Minister of Finance)* (1989), 57 D.L.R. (4th) 211 (F.C.T.D.).

83. *Supra*, note 65.

84. *Supra*, note 15.

85. *R. v. Big M Drug Mart Ltd.*, *supra*, note 68.

86. *Canadian Charter of Rights and Freedoms*, s. 24:

> 24.(1) Anyone whose rights or freedoms, as guaranteed by this Charter, have been infringed or denied may apply to a court of competent jurisdiction to obtain such remedy as the court considers appropriate and just in the circumstances.
>
> (2) Where, in proceedings under subsection (1), a court concludes that evidence was obtained in a manner that infringed or denied any rights or freedoms guaranteed by this Charter, the evidence shall be excluded if it is established that, having regard to all the circumstances, the admission of it in the proceedings would bring the administration of justice into disrepute.

This section contains two of the three remedial provisions found in the Charter. The language of ss. (1) — the general enforcement provision — should be interpreted at the least to extend to all appropriate forms of relief within the normal power of a particular level of court to grant such relief, e.g., prerogative remedies, damages, declarations, injunctions, etc.

87. *RWDSU v. Dolphin Delivery Ltd.* (1986), [1986] 2 S.C.R. 573 [hereinafter *Dolphin Delivery*]. For comments, see: Peter W. Hogg, "The Dolphin Delivery Case: The Application of the *Charter* to Private Action" (1987) 51 *Sask. L. Rev.* 273; Dale Gibson, "The *Charter of Rights* and the Private Sector" (1982) 12 *Man. L.J.* 213 and "Distinguishing the Governors from the Governed: The Meaning of Government under s. 32(1) of the *Charter*" (1982) 13 *Man. L.J.* 505; Brian Slattery, "The *Charter's* Relevance to Private Litigation: Does Dolphin Deliver?" (1987) 32 *McGill L.J.* 905.

88. *Ibid.*

89. See: Gibson, "The *Charter of Rights* and the Private Sector" and "Distinguishing the Governors from the Governed", *ibid.*; Dale Gibson, "Interpretation of the Canadian Charter of Rights and Freedoms: Some General Considerations" in Walter S. Tarnopolsky and Gérald-A. Beaudoin, eds., *The Canadian Charter of Rights and Freedoms: Commentary* (Toronto: Carswell, 1982), p. 25; Morris Manning, *Rights, Freedoms and the Courts: A Practical Analysis of the Constitution Act, 1982* (Toronto: Edmond-Montgomery, 1983).

90. Allan Hutchinson and Andrew Petter, "Private Rights/Public Wrongs: The Liberal Lie of the *Charter*" (1988) 38 *U.T.L.J.* 278 at 286.

91. For example, see: N. Colleen Sheppard, "Equality, Ideology and Oppression", *supra*, note 6.

92. The structure of health-care services in each province/territory must be scrutinized to determine the extent to which the Minister can exert control over the hospital board. For example, can the Minister appoint or dismiss members of the Board, does the Minister establish or approve the hospital's

by-laws, and can the Minister take control of the Board? See: *Hospital Act*, R.S.B.C. 1979, c. 176; *Hospitals Act*, R.S.A. 1980, c. H-11, s. 27-28; *Hospital Standards Act*, R.S.S. 1978, c. H-10, ss. 17-18; *Hospital Standards Amendment Act*, (Sask.), Bill 50, 1987 (to be proclaimed); *Hospitals Act*, R.S.M. 1987, c. H-120 (also C.C.S.M., c. H-120); *Public Hospitals Act*, R.S.O. 1980, c. 410 and R.R.O. 1980, Reg. 865, ss. 2-7; *An Act Respecting Health Services and Social Services*, R.S.Q. 1977, c. S-5, ss. 24, 76, 79, 96; *Hospitals Act*, S.N. 1971, c. 81, ss. 5, 18, 22, 26; *Hospitals Act*, R.S.N.S. 1977, c. 45, ss. 5, 17B; *Hospitals Act*, R.S.P.E.I. 1974, c. H-11, s. 17. Neither the Yukon Territory nor the Northwest Territories have comparable legislation yet. See also: *Medical Practitioners Act*, R.S.B.C. 1979, c. 254; *Medical Profession Act*, R.S.A. 1980, c. M-12; *Medical Profession Act*, S. Sask. 1980-81, c. M-10.1; *Medical Act*, R.S.M. 1987, c. M-90; *Health Disciplines Act*, R.S.O. 1980, c. 196; *Medical Act*, R.S.Q. 1977, c. M-9; *Medical Act*, S.N.S. 1969, c. 15 (consol. stats. of N.S., c. M-10); *An act respecting the New Brunswick medical society and the college of physicians and surgeons of New Brunswick*, S.N.B. 1981, c. 87; *Medical Act, 1974*, S. Nfld. 1974, c. 119; *Medical Act*, R.S.P.E.I. 1974, c. M-8 (repealed by *Medical Act*, S.P.E.I. 1987, c. 47 (not proclaimed as of 1 January 1988)); *Medical Profession Act*, N.W.T. (1983) (1), c. 10; *Medical Profession Act*, R.S.Y. 1986, c. 114.

93. Dale Gibson, *The Law of the Charter: General Principles* (Toronto: Carswell, 1986) at 105; Hogg, *supra*, note 9 at 677. It is clear that the legislation creating hospitals and their administrative structure must itself comply with Charter principles. It is less clear, however, whether all decisions taken by the board established under those laws must also comply with Charter principles or whether only particular kinds of decisions will qualify as government action.

94. Another approach used to determine whether Charter protections should apply to decisions taken by hospital boards is that of focussing on the purpose of the Charter interest allegedly infringed. Because a purposive approach has been adopted for interpreting the Charter protections, extending it to the question of when the Charter applies would not be inconsistent or novel. Hospitals rely on public funds to provide health-care services and consumers have looked to the government to provide quality health care as a public service for many years. Today, the *Canada Health Act* is the best evidence that health-care services are believed to fall within the public sphere or government domain.

95. Gibson, *supra*, note 93 at 103. See also: Donald Buckingham, *"The Canadian Charter of Rights and Freedoms* and Private Action Applying the Purposive Approach" (1986-87) 51 *Sask. L. Rev.* 105.

96. Gibson, *ibid.*

97. In *Stoffman v. Vancouver Gen. Hosp.* (1988), 21 B.C.L.R. (2d) 165 (B.C.C.A.) aff'g (1986), 30 D.L.R. (4th) 700 (B.C.S.C.), a hospital by-law establishing a policy of mandatory retirement was successfully challenged under the Charter because it infringed s. 15. The Supreme Court of Canada reserved judgement following argument on 16 and 17 May 1989.

98. For example, a B.C. hospital by-law, which attempted to withdraw admitting privileges from pregnant physicians, would create a situation similar to the facts in the *Stoffman* case; but, if a by-law purported to terminate medical services to pregnant women, it would be directed towards patients, not physicians.

99. *Andrews, supra*, note 5; *Re College of Physicians and Surgeons of Ontario and K* (1985), 16 D.L.R. (4th) 424 (Ont. Div. Ct.). The law society cases make the same point: *Law Society of Manitoba v. Savino* (1983), 1 D.L.R. (4th) 285 (Man. C.A.); *Law Society of Alberta v. Black* (1983), 8 D.L.R. (4th) 346 (Alta. C.A.); *Re Klein and Law Society of Upper Canada* (1985), 16 D.L.R. (4th) 489 (Ont. Div. Ct.).

100. With regard to fee-setting, the *Royal Commission on Health Services, supra*, note 63, vol. II, chap. 1 at p. 11 stated:

> Organized medicine is a statutory creation of legislations and of parliament. When the state grants a monopoly to an exclusive group to render an indispensable service it automatically becomes involved in whether those services are available and on what terms and conditions.

But at vol. 1, chap. 1, p. 12, it was said that medical professionals are not employees of the state.

101. Some provincial human rights codes prohibit discrimination only for "services customarily available to the public". The Sask. Q.B., in a decision reversed by the Sask. C.A., questioned whether a hospital is a facility to which the public is customarily admitted. See: *Peters v. University Hospital, Saskatoon* (1981), 2 C.H.R.R. D/358 (Sask. Bd. of Inquiry) rev'd (1981) 2 C.H.R.R. D/524 (Sask. Q.B.) rev'd [1983] 5 W.W.R. 193 (Sask. C.A.). Other cases, however, hold that the provision of social services benefits is a "service offered to the public". See: *Sask. (Human Rights Comm.) v. Sask. (Dept. of Social Services)* (1988), [1988] 5 W.W.R. 446 (Sask. C.A.).

102. *Re B.C. Motor Vehicle Act* (1985), [1985] 2 S.C.R. 486; *Singh v. Minister of Employment and Immigration* (1985), [1985] 1 S.C.R. 177.

103. Justice McIntyre in dissent in *Morgentaler, supra*, note 7 at 156-162.

104. See: Sheilah L. Martin, "The Reluctance of the Judiciary to Balance Competing Interests: *Morgentaler, Smoling et al.* in the Ontario Court of Appeal" (1986) 2 *Can. J.W.L.* 537.

105. For a comment, see: Sheilah L. Martin, "*Morgentaler v. The Queen* in the Supreme Court of Canada" (1987-88) 2 *Can. J.W.L.* 422.

106. *Supra*, note 7 at 24.

107. *Ibid.* at 52-53.

108. *Ibid.* at 113.

109. *Ibid.* at 119. Justice Wilson reviewed United States jurisprudence which precluded state intervention with such fundamentally personal decisions as education, childrearing, procreation, marriage, and contraception. *Ibid.* at 121-124. See: *Skinner v. Oklahoma*, 316 U.S. 535 (1942); *Griswold v. Connecticut*, 381 U.S. 479 (1965); *Eisenstadt v. Baird*, 405 U.S. 438 (1972); *Loving v. Virginia*, 388 U.S. 1 (1967); *Roe v. Wade*, 410 U.S. 113 (1973); *Doe v. Bolton*, 410 U.S. 179 (1973); *City of Akron v. Akron Centre for Reproductive Health, Inc.*, 462 U.S. 416 (1983); *Thornburgh v. American College of Obstetricians and Gynecologists*, 106 S.Ct. 2169 (1986).

110. *Supra*, note 7 at 125.

111. *Ibid.*

112. *Ibid.* at 128.

113. Section 2: "Everyone has the following fundamental freedoms: (a) freedom of conscience and religion . . ."

114. *Supra*, note 7 at 135.

115. Janet Gallagher, "Prenatal Invasions and Interventions: What's Wrong with Fetal Rights" (1987) 10 *Harv. Women's L.J.* 9 at 23.

116. *Bellotti v. Baird*, 443 U.S. 622 (1979); *Planned Parenthood v. Danforth*, 428 U.S. 52 (1976); *Doe v. Doe*, 314 N.E. 2d 128 (1974) where the Court held that the biological father had no rights under the Constitution to be a father or to protect the unborn fetus. For a discussion on whether notification rather than consent can be mandated, see: Helaine F. Lobman, "Spousal Notification: An Unconstitutional Limitation on a Woman's Right to Privacy in the Abortion Decision" (1984) 12 *Hofstra L. Rev.* 531. She concludes that state interest in promoting marital harmony, protecting the procreative potential of the marriage, and protecting the husband's interest in the fetus are not sufficiently compelling to protect these statutes from constitutional attack.

117. In *City of Akron v. Akron Centre for Reproductive Health* (462 v.s. at 445), the U.S. Court indicated that it looks with disfavour on statutes that are

> . . . designed not to inform the woman's consent but rather to persuade her to withhold it altogether. Moreover, requiring that specific information be conveyed is likely to run afoul of the Court's desire to prevent the state from intruding upon the discretion of the pregnant woman's physician. The majority opinion in *Thornburgh* indicates even greater hostility to 'informed consent' provisions.

See: *Thornburgh v. American College of Obstetricians and Gynecologists*, 106 S. Ct. 2169 (1986), aff'g, 737 F. 2d 283 (3d Cir. 1985).

118. *Supra*, note 109.

119. *Maher v. Roe*, 432 U.S. 464 (1977) at 474. See also: *Harris v. McRae*, 448 U.S. 297 (1980) where a denial of funding for medically necessary abortions did not unconstitutionally impair a woman's protected rights to decide whether or not to terminate her pregnancy. In *Williams v. Zbaraz*, 448 U.S. 358 (1980), the Court came to the same conclusion even though the plaintiff also advanced an equal protection argument under the Fourteenth Amendment.

120. *Buck v. Bell*, 274 U.S. 200 (1927) at 208.

121. *Moe v. Secretary of Administration, Mass.*, 417 N.E. 2d 387 (1981). [Editor's note: Although the recent decision of the U.S. Supreme Court in *Webster v. Reproductive Health Services*, (8 July 1989), No. 88-605 U.S. Sup. Ct., unreported, rejects this approach, the Court suggests that "a different analysis might apply if a particular state had socialized medicine and all of its hospitals and physicians were publicly funded." (at 20).]

122. Choice without control is similar to, and as empty as, rights without services. Control focusses on power, not freedom, and access to services, not just the notional chance of their availability. For example, the lexicon of choice may encourage women to uncritically welcome any new reproductive technologies because their addition appears to increase women's options by expanding the range of choice. This may be dangerous because it gives the false impression that women controlled their evolution, participated in the end product, wanted the technologies, and are somehow liberated by their availability.

123. For a review of s. 28, see: Katharine J. de Jong, "Sexual Equality: Interpreting Section 28" in Bayefsky and Eberts, eds., *Equality Rights and the Canadian Charter of Rights and Freedoms*, *supra*, note 6 at 493.

124. *Supra*, note 5.

125. *Ibid.* at 262.

126. *Ibid.* at 266.

127. *Supra*, note 11.

128. Laurie Nsiah-Jefferson, "Reproductive Laws, Women of Color, and Low-Income Women" in Nadine Taub and Sherrill Cohen, eds., *Reproductive Laws of the 1990's* (Newark, N.J.: Women's Rights Litigation Clinic, School of Law, Institute for Research on Women, 1988), pp. 17-58.

129. For a general discussion of the judicial treatment of pregnancy, see: Sheilah L. Martin, "Persisting Equality Implications of the Bliss Case" in Martin and Mahoney, *Equality and Judicial Neutrality, supra*, note 52 at 195.

130. Rebecca Cook and Bernard Dickens, "A Decade of International Change in Abortion Law: 1967-1977", *American Journal of Public Health*, July 1978, vol. 68, no. 7, p. 637.

131. *Supra*, note 7.

132. For example, why should such extensive resources be allocated to procedures such as *in vitro* fertilization, which is directed towards the infertility of one person, rather than to study, cure, or prevent the systematic causes of women's infertility?

133. *Supra*, note 5.

134. *Brooks v. Canada Safeway Ltd.* (4 May 1989) No. 20131 (S.C.C.).

135. *Janzen v. Platy Enterprises Ltd.* (4 May 1989) No. 20241 (S.C.C.).

136. (1978), [1979] 1 S.C.R. 183 [hereinafter *Bliss*].

137. R.S.C. 1970, App. III, s. 1(b).

> 1. It is hereby recognized and declared that in Canada there have existed and shall continue to exist without discrimination by reason of . . . sex, the following human rights and fundamental freedoms, namely,
>
> (b) the right of the individual to equality before the law and the protection of the law . . .

138. *Unemployment Insurance Act, 1971*, S.C. 1970-71, c. 48, ss. 46, 30.

139. See: *supra*, note 67.

140. *Supra*, note 134.

141. *The Human Rights Act*, S.M. 1974, c. 65, s. 6(1).

142. *Supra*, note 134 at 27.

143. Quoted from the appellant's factum, *ibid.* at 28.

144. *Supra*, note 135.

145. At a local level, the decisions of hospital administrators, and even the very election of those administrators to their positions, are often based on moral judgements about women's reproductive rights, not fiscal policies.

146. Some statutes in Canada and the United States give express recognition to pregnancy discrimination as sex discrimination:

> *Canadian Human Rights Act*, S.C. 1976-77, c. 33; *Saskatchewan Human Rights Code*, S. Sask. 1979, C. S-24.1; *Quebec Charter of Human Rights and Freedoms*, R.S.Q. 1977, c. C-12;
>
> *Pregnancy Discrimination Act*, 42 U.S.C. ss. 2000(e), Title VII, as amended by the *Pregnancy Discrimination Act of 1978*, 42 U.S.C. ss. 2000(e), (k) (1982).

147. *Supra*, note 5.

148. Catharine A. MacKinnon, *Feminism Unmodified: Discourses on Life and Law* (Cambridge, Mass.: Harvard University Press, 1987), p. 31.

149. Catharine A. MacKinnon, *The Sexual Harassment of Working Women* (New Haven: Yale University Press, 1979).

150. *Supra*, note 5 at 294.

151. *Ibid.* at 297.

152. *Supra*, note 149.

153. Factum of the Women's Legal Education and Action Fund (Intervenor) in *Borowski v. Can. A.G.* (9 March 1989) No. 20411 (S.C.C.); 1987, [1987] 4 W.W.R. 385 (Sask. C.A.).

154. *Ibid.*, para. 49.

155. *Ibid.*, paras. 50, 51.

156. *Ibid.*, para. 52.

157. *Ibid.*

158. *Ibid.*, para. 53.

159. *Ibid.*

160. *Ibid.*, para. 54.

161. See also: Canadian Advisory Council on the Status of Women, *Council Recommendations: Reproductive Health* (Ottawa: March 1988), listed under E2.3.

Whereas

- the Supreme Court of Canada struck down section 251 (abortion) of the Criminal Code on January 28, 1988;
- access to reproductive health services, including abortion, is inequitable across the country;

the CACSW adopts the following reproductive health principles:

1. Reproductive choice is an equality issue. In our society, women become pregnant, bear and raise children under conditions of inequality. Partial remedies for these inequities include: increased child care facilities; economic self-sufficiency for women; research to develop safe methods of contraception; access to a full range of reproductive health services; development of information, resources and services to support family planning and birth control; sex education; and access to abortion.
2. A pregnant woman has the right to determine the best medical treatment for herself or the fetus she is carrying, in consultation with advisors of her choice and without threat of third party intervention or obstruction. No woman should be penalized for making a decision which she believes furthers her physical and mental health, the health of her children, the health of her family as a whole, or the health of any fetus she is carrying.
3. A pregnant woman who has made the decision to have an abortion should have access to abortion services at the earliest opportunity, and should not be forced into a late term abortion or denied access altogether by reason of obstructive diagnostic procedures and practices, financial impediments, geographic location or legal or quasi-legal proceedings. Reproductive health services and abortion must be available to women equitably throughout Canada, and funded completely by provincial health insurance plans, in keeping with the principles of universality, accessibility and comprehensiveness as stated in the Canada Health Act.
4. The Criminal Code and provincial regulation of medical standards and practitioners continue to provide adequate protection against malpractice and unqualified practitioners, and to ensure that the best medical practice under the circumstances is observed. No further legislation is necessary or warranted.

162. *Ibid.*, para. 55.

163. *R. v. Oakes* (1986), [1986] 1 S.C.R. 103.

164. Powell Report, *supra*, note 11.

165. For example, most hospital abortions are done under general anaesthetic, and the vacuum aspiration technique is not used in some provinces.

166. Powell Report, *supra*, note 11.

167. *Supra*, note 130.

168. *Dehler v. Ottawa Civic Hospital* (1979), 25 O.R. (2d) 748 (H.C.J.) at 757:

> Since the law does not regard an unborn child as an independent legal entity prior to birth, it is not recognized as having the rights the plaintiff asserts on its behalf or the status to maintain an action. A fetus, whatever its stage of development, is recognized as a person in the full sense only after birth.

See also: *Borowski v. Can. A.G.* (1983), [1984] 1 W.W.R. 15 (Sask. Q.B.) aff'd [1987] 4 W.W.R. 385 (Sask. C.A.).

Borowski's arguments were rejected at trial and by the Saskatchewan Court of Appeal. Both courts held that constitutional rights vest at the time of birth, not conception.

169. In *Borowski v. A.G. Canada, supra,* note 153, the Supreme Court refused to answer the abstract and vague questions which Borowski's appeal raised because there was no state action in issue.

170. *Supra,* note 130.

Appendix 1: Table of Cases

— Andrews v. Law Society of British Columbia (1989), 91 N.R. 255 (S.C.C.)
— B.C. Civil Liberties Assn. v. B.C. (A.G.) (1988), 24 B.C.L.R. (2d) 189 (B.C.S.C.)
— Bellotti v. Baird, 443 U.S. 622 (1979)
— Bliss v. A.G. Canada (1978), [1979] 1 S.C.R. 183
— Borowski v. Can. A.G. (9 March 1989) No. 20411 (S.C.C.); (1987), [1987] 4 W.W.R. 385 (Sask. C.A.);
— Borowski v. Can. A.G. (1983), [1984] 1 W.W.R. 15 (Sask. Q.B.)
— Brooks v. Canada Safeway Ltd. (4 May 1989) No. 20131 (S.C.C.)
— Buchan v. Ortho Pharmaceutical (Canada) Ltd. (1986), 35 C.C.L.T. 1 (Ont. C.A.)
— Buck v. Bell, 274 U.S. 200 (1927)
— Carruthers v. Therapeutic Abortion Committees (1983), 6 D.L.R. (4th) 57
— City of Akron v. Akron Centre for Reproductive Health, Inc., 462 U.S. 416 (1983)
— Dehler v. Ottawa Civic Hospital (1979), 25 O.R. (2d) 748 (H.C.J.)
— Doe v. Bolton, 410 U.S. 179 (1973)
— Doe v. Doe, 314 N.E. 2d 128 (1974)
— Eisenstadt v. Baird, 405 U.S. 438 (1972)
— Finlay v. Can. (Minister of Finance) (1986), [1987], 1 W.W.R. 603 (S.C.C.)
— Finlay v. Canada (Minister of Finance) (1989), 57 D.L.R. (4th) 211 (F.C.T.D.)
— Fredette v. Wiebe (1986), 37 C.C.L.T. 106 (B.C.S.C.)
— Griswold v. Connecticut, 381 U.S. 479 (1965)
— Harris v. McRae, 448 U.S. 297 (1980)
— Janzen v. Platy Enterprises Ltd. (4 May 1989) No. 20241 (S.C.C.)
— Joe v. Y.T. (Dir. of Fam. & Children's Services) (1986), 5 B.C.L.R. (2d) 267 (Y.T.S.C.)
— Labatt Breweries of Canada Ltd. v. A.G. Canada (1979), [1980] 1 S.C.R. 914
— Law Society of Alberta v. Black (1983), 8 D.L.R. (4th) 346 (Alta. C.A.)
— Law Society of Manitoba v. Savino (1983), 1 D.L.R. (4th) 285 (Man. C.A.)
— Loving v. Virginia, 388 U.S. 1 (1967)
— Maher v. Roe, 432 U.S. 464 (1977)
— Moe v. Secretary of Administration, Mass., 417 N.E. 2d 387 (1981)
— Morgentaler v. A.G. New Brunswick, [1989] N.B.J. No. 311; (13 April 1989), N.B.Q.B. F/M/103/88
— People v. Pamela Rae Stewart, (26 February 1987) Calif. Crim. Docket No. M-508187 (Calif. Mun. Ct.)
— Peters v. University Hospital, Saskatoon (1981), 2 C.H.R.R. D/358 (Sask. Bd. of Inquiry) rev'd (1981), 2 C.H.R.R. D/524 (Sask. Q.B.) rev'd [1983] 5 W.W.R. 193 (Sask. C.A.)
— Planned Parenthood v. Danforth, 428 U.S. 52 (1976)
— R. v. Big M Drug Mart Ltd., [1985] 1 S.C.R. 295
— R. v. Crown Zellerbach Canada Ltd. (1988), [1988] 1 S.C.R. 401
— R. v. Hauser (1979), [1979] 1 S.C.R. 984
— R. v. Morgentaler (1988), 82 N.R. 1 (S.C.C.)
— R. v. Oakes (1986), [1986] 1 S.C.R. 103
— R. v. Sullivan (1988), 31 B.C.L.R. (2d) 145 (B.C.C.A.)
— R. v. Wetmore (1983), [1983] 2 S.C.R. 284
— Re Baby R. (1988), 15 R.F.L. (3d) 225 (B.C.S.C) rev'g (1987), 9 R.F.L. (3d) 415 (B.C. Prov. Ct.)
— Re B.C. Motor Vehicle Act (1985), [1985] 2 S.C.R. 486

— Re Children's Aid Society for the District of Kenora and J.L. (1981), 134 D.L.R. (3d) 249 (Ont. Prov. Ct.)
— Re Children's Aid Society of City of Belleville and T. (1987), 59 O.R. (2d) 204 (Ont. Prov. Ct.)
— Re College of Physicians and Surgeons of Ontario and K (1985), 16 D.L.R. (4th) 424 (Ont. Div. Ct.)
— Re Klein and Law Society of Upper Canada (1985), 16 D.L.R. (4th) 489 (Ont. Div. Ct.)
— Re Law Society of Manitoba and Savino (1983), 1 D.L.R. (4th) 285 (Man. C.A.)
— Re Superintendent of Family and Child Service and McDonald (1982), 135 D.L.R. (3d) 330 (B.C.S.C.)
— Reference Re Freedom of Informed Choice (Abortions) Act (1985), 25 D.L.R. (4th) 751 (Sask. C.A.)
— Roe v. Wade, 410 U.S. 113 (1973)
— RWDSU v. Dolphin Delivery Ltd. (1986), [1986] 2 S.C.R. 573
— Sask. (Human Rights Comm.) v. Sask. (Dept. of Social Services) (1988), [1988] 5 W.W.R. 446 (Sask. C.A.)
— Sask. Medical Association v. Medical Comp. Review Board (Sask.) (1987), 62 Sask. R. 179 (Sask. Q.B.)
— Schneider v. The Queen (1982), [1982] 2 S.C.R. 112
— Singh v. Minister of Employment and Immigration (1985), [1985] 1 S.C.R. 177
— Skinner v. Oklahoma, 316 U.S. 535 (1942)
— Stoffman v. Vancouver Gen. Hosp. (1988), 21 B.C.L.R. (2d) 165 (B.C.C.A.) aff'g (1986), 30 D.L.R. (4th) 700 (B.C.S.C.)
— Supt. of Family and Child Service v. M.(B.) (1982), 28 R.F.L. (2d) 278 (B.C.S.C.)
— Thornburgh v. American College of Obstetricians and Gynecologists, 106 S.Ct. 2169 (1986)
— Webster v. Reproductive Health Services, (8 July 1989) No. 88-605 (U.S. Sup. Ct.)
— Williams v. Zbaraz, 448 U.S. 358 (1980)
— Winterhaven Stables Ltd. v. Canada (A.G.) (1986), 71 A.R. 1 (Alta. Q.B.)
— Zimmer v. Ringrose (1981), 28 A.R. 69 (Alta. C.A.)

Appendix 2: Selected Sections of the Canadian Charter of Rights and Freedoms

I Life, Liberty and Security of the Person

7. Everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice.

II Equality Guarantees

15.(1) Every individual is equal before and under the law and has the right to the equal protection and equal benefit of the law without discrimination and, in particular, without discrimination based on race, national or ethnic origin, colour, religion, sex, age or mental or physical disability.

(2) Subsection (1) does not preclude any law, program or activity that has as its object the amelioration of conditions of disadvantaged individuals or groups including those that are disadvantaged because of race, national or ethnic origin, colour, religion, sex, age or mental or physical disability.

28. Notwithstanding anything in this Charter, the rights and freedoms referred to in it are guaranteed equally to male and female persons.

III Limits

1. The *Canadian Charter of Rights and Freedoms* guarantees the rights and freedoms set out in it subject only to such reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society.

33.(1) Parliament or the legislature of a province may expressly declare in an Act of Parliament or of the legislature, as the case may be, that the Act or a provision thereof shall operate nothwithstanding a provision included in section 2 or sections 7 to 15 of this Charter.

IV Scope

32.(1) This Charter applies

(a) to the Parliament and government of Canada in respect of all matters within the authority of Parliament including all matters relating to the Yukon Territory and Northwest Territories; and

(b) to the legislature and government of each province in respect of all matters within the authority of the legislature of each province.

V Remedies

24.(1) Anyone whose rights or freedoms, as guaranteed by this Charter, have been infringed or denied may apply to a court of competent jurisdiction to obtain such remedy as the court considers appropriate and just in the circumstances.

52.(1)* The Constitution of Canada is the supreme law of Canada, and any law that is inconsistent with the provisions of the Constitution is, to the extent of the inconsistency, of no force or effect.

*Although technically not part of the Charter, this section is part of the Constitution and is relevant to Charter remedies.

Appendix 3: Selected Sections of the Constitution Act, 1867

I Powers of the Parliament

91. It shall be lawful for the Queen, by and with the Advice and Consent of the Senate and House of Commons, to make Laws for the Peace, Order, and good Government of Canada, in relation to all Matters not coming within the Classes of Subjects by this Act assigned exclusively to the Legislatures of the Provinces; and for greater Certainty, but not so as to restrict the Generality of the foregoing Terms of this Section, it is hereby declared that (notwithstanding anything in this Act) the exclusive Legislative Authority of the Parliament of Canada extends to all Matters coming within the Classes of Subjects next herein-after enumerated; that is to say,—

(1A) The Public Debt and Property.

(3) The raising of Money by any Mode or System of Taxation.

(27) The Criminal Law, except the Constitution of Courts of Criminal Jurisdiction, but including the Procedure in Criminal Matters.

And any Matter coming within any of the Classes of Subjects enumerated in this Section shall not be deemed to come within the Class of Matters of a local or private Nature comprised in the Enumeration of the Classes of Subjects by this Act assigned exclusively to the Legislatures of the Provinces.

II Exclusive Powers of Provincial Legislatures

92. In each Province the Legislature may exclusively make Laws in relation to Matters coming within the Classes of Subjects next herein-after enumerated; that is to say,—

(7) The Establishment, Maintenance, and Management of Hospitals, Asylums, Charities, and Eleemosynary Institutions in and for the Province, other than Marine Hospitals.

(13) Property and Civil Rights in the Province.

(16) Generally all Matters of a merely local or private Nature in the Province.

Appendix 4: Canada Health Act

CHAPTER C-6

An Act relating to cash contributions by Canada in respect of insured health services provided under provincial health care insurance plans and amounts payable by Canada in respect of extended health care services

Preamble

WHEREAS the Parliament of Canada recognizes:

— that it is not the intention of the Government of Canada that any of the powers, rights, privileges or authorities vested in Canada or the provinces under the provisions of the *Constitution Act, 1867*, or any amendments thereto, or otherwise, be by reason of this Act abrogated or derogated from or in any way impaired;
— that Canadians, through their system of insured health services, have made outstanding progress in treating sickness and alleviating the consequences of disease and disability among all income groups;
— that Canadians can achieve further improvements in their well-being through combining individual lifestyles that emphasize fitness, prevention of disease and health promotion with collective action against the social, environmental and occupational causes of disease, and that they desire a system of health services that will promote physical and mental health and protection against disease;
— that future improvements in health will require the cooperative partnership of governments, health professionals, voluntary organizations and individual Canadians;
— that continued access to quality health care without financial or other barriers will be critical to maintaining and improving the health and well-being of Canadians;

AND WHEREAS the Parliament of Canada wishes to encourage the development of health services throughout Canada by assisting the provinces in meeting the costs thereof;

NOW, THEREFORE, Her Majesty, by and with the advice and consent of the Senate and House of Commons of Canada, enacts as follows:

SHORT TITLE

Short title

1. This Act may be cited as the *Canada Health Act*. 1984, c. 6, s. 1.

INTERPRETATION

Definitions

2. In this Act,

"Act of 1977" "Act of 1977" means the *Federal-Provincial Fiscal Arrangements and Federal Post-Secondary Education and Health Contributions Act*;

"cash contribution" "cash contribution" means the amount of the established programs cash contribution referred to in paragraph 13(1)(b) of the Act of 1977 that is allocated by the Minister of Finance under section 19 of that Act in respect of the insured health services program of a province;

"contribution" "contribution" means the established programs financing contribution referred to in paragraphs 13(1)(a) and (b) of the Act of 1977 that may be provided to a province in respect of the insured health services program of the province;

"dentist" "dentist" means a person lawfully entitled to practise dentistry in the place in which the practice is carried on by that person;

"extended health care services" "extended health care services" means the following services, as more particularly defined in the regulations, provided for residents of a province, namely,

(a) nursing home intermediate care service,
(b) adult residential care service,
(c) home care service, and
(d) ambulatory health care service;

"extra-billing" "extra-billing" means the billing for an insured health service rendered to an insured person by a medical practitioner or a dentist in an amount in addition to any amount paid or to be paid for that service by the health care insurance plan of a province;

"health care insurance plan" "health care insurance plan" means, in relation to a province, a plan or plans established by the law of the province to provide for insured health services;

"health care practitioner" "health care practitioner" means a person lawfully entitled under the law of a province to provide health services in the place in which the services are provided by that person;

"hospital" "hospital" includes any facility or portion thereof that provides hospital care, including acute, rehabilitative or chronic care, but does not include

(a) a hospital or institution primarily for the mentally disordered, or
(b) a facility or portion thereof that provides nursing home intermediate care service or adult residential care service, or comparable services for children;

"hospital services" means any of the following services provided to in-patients or out-patients at a hospital, if the services are medically necessary for the purpose of maintaining health, preventing disease or diagnosing or treating an injury, illness or disability, namely,

(a) accommodation and meals at the standard or public ward level and preferred accommodation if medically required,
(b) nursing service,
(c) laboratory, radiological and other diagnostic procedures, together with the necessary interpretations,
(d) drugs, biologicals and related preparations when administered in the hospital,
(e) use of operating room, case room and anaesthetic facilities, including necessary equipment and supplies,
(f) medical and surgical equipment and supplies,
(g) use of radiotherapy facilities,
(h) use of physiotherapy facilities, and
(i) services provided by persons who receive remuneration therefor from the hospital,

but does not include services that are excluded by the regulations;

"insured health services" means hospital services, physician services and surgical-dental services provided to insured persons, but does not include any health services that a person is entitled to and eligible for under any other Act of Parliament or under any Act of the legislature of a province that relates to workers' or workmen's compensation;

"insured person" means, in relation to a province, a resident of the province other than

(a) a member of the Canadian Forces,
(b) a member of the Royal Canadian Mounted Police who is appointed to a rank therein,
(c) a person serving a term of imprisonment in a penitentiary as defined in the *Penitentiary Act*, or
(d) a resident of the province who has not completed such minimum period of residence or waiting period, not exceeding three months, as may be required by the province for eligibility for or entitlement to insured health services;

"medical practitioner" means a person lawfully entitled to practise medicine in the place in which the practice is carried on by that person;

"Minister" means the Minister of National Health and Welfare;

"physician services" means any medically required services rendered by medical practitioners;

"resident" means, in relation to a province, a person lawfully entitled to be or to remain in Canada who makes his home and is ordinarily present in the province, but does not include a tourist, a transient or a visitor to the province;

"surgical-dental services"

"surgical-dental services" means any medically or dentally required surgical-dental procedures performed by a dentist in a hospital, where a hospital is required for the proper performance of the procedures;

"user charge"

"user charge" means any charge for an insured health service that is authorized or permitted by a provincial health care insurance plan that is not payable, directly or indirectly, by a provincial health care insurance plan, but does not include any charge imposed by extra-billing. 1984, c. 6, ss. 2, 33.

CANADIAN HEALTH CARE POLICY

Primary objective of Canadian health care policy

3. It is hereby declared that the primary objective of Canadian health care policy is to protect, promote and restore the physical and mental well-being of residents of Canada and to facilitate reasonable access to health services without financial or other barriers. 1984, c. 6, s. 3.

PURPOSE

Purpose of this Act

4. The purpose of this Act is to establish criteria and conditions that must be met before full payment may be made under the Act of 1977 in respect of insured health services and extended health care services provided under provincial law. 1984, c. 6, s. 4.

CASH CONTRIBUTIONS AND PAYMENTS

Cash contribution

5. Subject to this Act, as a part of the contribution provided by Canada to each province, a full cash contribution is payable under the Act of 1977 for each fiscal year in respect of the cost of insured health services provided under a health care insurance plan of the province. 1984, c. 6, s. 5.

Amount payable for extended health care services

6. In addition to the cash contribution referred to in section 5, a full amount is payable by Canada to each province under section 23 of the Act of 1977 for each fiscal year in respect of the extended health care services program if the province complies with the conditions set out in section 13 of this Act. 1984. c. 6, s. 6.

PROGRAM CRITERIA

Program criteria

7. In order that a province may qualify for a full cash contribution referred to in section 5 for a fiscal year, the health care insurance plan of the province must, throughout the fiscal year, satisfy the criteria described in sections 8 to 12 respecting the following matters:

(a) public administration;
(b) comprehensiveness;
(c) universality;
(d) portability; and
(e) accessibility. 1984, c. 6, s. 7.

Public administration

8. (1) In order to satisfy the criterion respecting public administration,

(a) the health care insurance plan of a province must be administered and operated on a non-profit basis by a public authority appointed or designated by the government of the province;
(b) the public authority must be responsible to the provincial government for that administration and operation; and
(c) the public authority must be subject to audit of its accounts and financial transactions by such authority as is charged by law with the audit of the accounts of the province.

Designation of agency permitted

(2) The criterion respecting public administration is not contravened by reason only that the public authority referred to in subsection (1) has the power to designate any agency

(a) to receive on its behalf any amounts payable under the provincial health care insurance plan; or
(b) to carry out on its behalf any responsibility in connection with the receipt or payment of accounts rendered for insured health services, if it is a condition of the designation that all those accounts are subject to assessment and approval by the public authority and that the public authority shall determine the amounts to be paid in respect thereof. 1984, c. 6, s. 8.

Comprehensiveness

9. In order to satisfy the criterion respecting comprehensiveness, the health care insurance plan of a province must insure all insured health services provided by hospitals, medical practitioners or dentists, and where the law of the province so permits, similar or additional services rendered by other health care practitioners. 1984, c. 6, s. 9.

Universality

10. In order to satisfy the criterion respecting universality, the health care insurance plan of a province must entitle one hundred per cent of the insured persons of the province to the insured health services provided for by the plan on uniform terms and conditions. 1984, c. 6, s. 10.

Portability

11. (1) In order to satisfy the criterion respecting portability, the health care insurance plan of a province

(a) must not impose any minimum period of residence in the province, or waiting period, in excess of three months before residents of the province are eligible for or entitled to insured health services;

(b) must provide for and be administered and operated so as to provide for the payment of amounts for the cost of insured health services provided to insured persons while temporarily absent from the province on the basis that

(i) where the insured health services are provided in Canada, payment for health services is at the rate that is approved by the health care insurance plan of the province in which the services are provided, unless the provinces concerned agree to apportion the cost between them in a different manner, or

(ii) where the insured health services are provided out of Canada, payment is made on the basis of the amount that would have been paid by the province for similar services rendered in the province, with due regard, in the case of hospital services, to the size of the hospital, standards of service and other relevant factors; and

(c) must provide for and be administered and operated so as to provide for the payment, during any minimum period of residence, or any waiting period, imposed by the health care insurance plan of another province, of the cost of insured health services provided to persons who have ceased to be insured persons by reasons of having become residents of that other province, on the same basis as though they had not ceased to be residents of the province.

Requirement for consent for elective insured health services permitted

(2) The criterion respecting portability is not contravened by a requirement of a provincial health care insurance plan that the prior consent of the public authority that administers and operates the plan must be obtained for elective insured health services provided to a resident of the province while temporarily absent from the province if the services in question were available on a substantially similar basis in the province.

Definition of "elective insured health services"

(3) For the purpose of subsection (2), "elective insured health services" means insured health services other than services that are provided in an emergency or in any other circumstance in which medical care is required without delay. 1984, c. 6, s. 11.

Accessibility

12. (1) In order to satisfy the criterion respecting accessibility, the health care insurance plan of a province

(a) must provide for insured health services on uniform terms and conditions and on a basis that does not impede or preclude, either directly or indirectly whether by charges made to insured persons or otherwise, reasonable access to those services by insured persons;

(b) must provide for payment for insured health services in accordance with a tariff or system of payment authorized by the law of the province;

(c) must provide for reasonable compensation for all insured health services rendered by medical practitioners or dentists; and

(d) must provide for the payment of amounts to hospitals, including hospitals owned or operated by Canada, in respect of the cost of insured health services.

Reasonable compensation

(2) In respect of any province in which extra-billing is not permitted, paragraph (1)(c) shall be deemed to be complied with if the province has chosen to enter into, and has entered into, an agreement with the medical practitioners and dentists of the province that provides

(a) for negotiations relating to compensation for insured health services between the province and provincial organizations that represent practising medical practitioners or dentists in the province;

(b) for the settlement of disputes relating to compensation through, at the option of the appropriate provincial organizations referred to in paragraph (a), conciliation or binding arbitration by a panel that is equally representative of the provincial organizations and the province and that has an independent chairman; and

(c) that a decision of a panel referred to in paragraph (b) may not be altered except by an Act of the legislature of the province. 1984, c. 6, s. 12.

CONDITIONS FOR CASH CONTRIBUTIONS OR PAYMENTS

Conditions

13. In order that a province may qualify for a full cash contribution referred to in section 5 or payment of the full amount referred to in section 6 for a fiscal year, the government of the province

(a) shall, at the times and in the manner prescribed by the regulations, provide the Minister with such information, of a type prescribed by the regulations, as the Minister may reasonably require for the purposes of this Act; and

(b) shall give recognition to the contributions and payments by Canada under this Act in any public documents, or in any advertising or promotional material, relating to insured health services and extended health care services in the province. 1984, c. 6, s. 13.

DEFAULTS

Referral to Governor in Council

14. (1) Subject to subsection (3), where the Minister, after consultation in accordance with subsection (2) with the minister responsible for health care in a province, is of the opinion that

(a) the health care insurance plan of the province does not or has ceased to satisfy any one of the criteria described in sections 8 to 12, or

(b) the province has failed to comply with any condition set out in section 13,

and the province has not given an undertaking satisfactory to the Minister to remedy the default within a period that the Minister considers reasonable, the Minister shall refer the matter to the Governor in Council.

Consultation process

(2) Before referring a matter to the Governor in Council under subsection (1) in respect of a province, the Minister shall

(a) send by registered mail to the minister responsible for health care in the province a notice of concern with respect to any problem foreseen;

(b) seek any additional information available from the province with respect to the problem through bilateral discussions, and make a report to the province within ninety days after sending the notice of concern; and

(c) if requested by the province, meet within a reasonable period of time to discuss the report.

Where no consultation can be achieved

(3) The Minister may act without consultation under subsection (1) if the Minister is of the opinion that a sufficient time has expired after reasonable efforts to achieve consultation and that consultation will not be achieved. 1984, c. 6, s. 14.

Order reducing or withholding contribution

15. (1) Where, on the referral of a matter under section 14, the Governor in Council is of the opinion that the health care insurance plan of a province does not or has ceased to satisfy any one of the criteria described in sections 8 to 12 or that a province has failed to comply with any condition set out in section 13, the Governor in Council may, by order,

(a) direct that any cash contribution or amount payable to that province for a fiscal year be reduced, in respect of each default, by an amount that the Governor in Council considers to be appropriate, having regard to the gravity of the default; or

(b) where the Governor in Council considers it appropriate, direct that the whole of any cash contribution or amount payable to that province for a fiscal year be withheld.

Amending orders

(2) The Governor in Council may, by order, repeal or amend any order made under subsection (1) where the Governor in Council is of the opinion that the repeal or amendment is warranted in the circumstances.

Notice of order

(3) A copy of each order made under this section together with a statement of any findings on which the order was based shall be sent forthwith by registered mail to the government of the province concerned and the Minister shall cause the order and statement to be laid before each House of Parliament on any of the first fifteen days on which that House is sitting after the order is made.

Commencement of order

(4) An order made under subsection (1) shall not come into force earlier than thirty days after a copy of the order has been sent to the government of the province concerned under subsection (3). 1984, c. 6, s. 15.

Reimposition of reductions or withholdings

16. In the case of a continuing failure to satisfy any of the criteria described in sections 8 to 12 or to comply with any condition set out in section 13, any reduction or withholding under section 15 of a cash contribution or an amount payable to a province for a fiscal year shall be reimposed for each succeeding fiscal year as long as the Minister is satisfied, after consultation with the minister responsible for health care in the province, that the default is continuing. 1984, c. 6, s. 16.

When reduction or withholding imposed

17. Any reduction or withholding under section 15 or 16 of a cash contribution or payment may be imposed in the fiscal year in which the default that gave rise to the reduction or withholding occurred or in the following fiscal year. 1984, c. 6, s. 17.

EXTRA-BILLING AND USER CHARGES

Extra-billing

18. In order that a province may qualify for a full cash contribution referred to in section 5 for a fiscal year, no payments may be permitted by the province for that fiscal year under the health care insurance plan of the province in respect of insured health services that have been subject to extra-billing by medical practitioners or dentists. 1984, c. 6, s. 18.

User charges

19. (1) In order that a province may qualify for a full cash contribution referred to in section 5 for a fiscal year, user charges must not be permitted by the province for that fiscal year under the health care insurance plan of the province.

Limitation

(2) Subsection (1) does not apply in respect of user charges for accommodation or meals provided to an in-patient who, in the opinion of the attending physician, requires chronic care and is more or less permanently resident in a hospital or other institution. 1984, c. 6, s. 19.

Deduction for extra-billing

20. (1) Where a province fails to comply with the condition set out in section 18, there shall be deducted from the cash contribution to the province for a fiscal year an amount that the Minister, on the basis of information provided in accordance with the regulations, determines to have been charged through extra-billing by medical practitioners or dentists in the province in that fiscal year or, where information is not provided in accordance with the regulations, an amount that the Minister estimates to have been so charged.

Deduction for user charges

(2) Where a province fails to comply with the condition set out in section 19, there shall be deducted from the cash contribution to the province for a fiscal year an amount that the Minister, on the basis of information provided in accordance with the regulations, determines to have been charged in the province in respect of user charges to which section 19 applies in that fiscal year or, where information is not provided in accordance with the regulations, an amount that the Minister estimates to have been so charged.

Consultation with province

(3) The Minister shall not estimate an amount under subsection (1) or (2) without first undertaking to consult the minister responsible for health care in the province concerned.

Separate accounting in Public Accounts

(4) Any amount deducted under subsection (1) or (2) from a cash contribution in any of the three consecutive fiscal years the first of which commences on April 1, 1984 shall be accounted for separately in respect of each province in the Public Accounts for each of those fiscal years in and after which the amount is deducted.

Refund to province

(5) Where, in any of the three fiscal years referred to in subsection (4), extra-billing or user charges have, in the opinion of the Minister, been eliminated in a province, the total amount deducted in respect of extra-billing or user charges, as the case may be, shall be paid to the province.

Saving

(6) Nothing in this section restricts the power of the Governor in Council to make any order under section 15. 1984, c. 6, s. 20.

When deduction made

21. Any deduction from a cash contribution under section 20 may be made in the fiscal year in which the matter that gave rise to the deduction occurred or in the following two fiscal years. 1984, c. 6, s. 21.

REGULATIONS

Regulations

22. (1) Subject to this section, the Governor in Council may make regulations for the administration of this Act and for carrying its purposes and provisions into effect, including, without restricting the generality of the foregoing, regulations

(a) defining the services referred to in paragraphs (a) to (d) of the definition "extended health care services" in section 2;

(b) prescribing the services excluded from hospital services;

(c) prescribing the types of information that the Minister may require under paragraph 13(a) and the times at which and the manner in which that information shall be provided; and

(d) prescribing the manner in which recognition to contributions and payments by Canada under this Act is required to be given under paragraph 13(b).

Agreement of provinces

(2) Subject to subsection (3), no regulation may be made under paragraph (1)(a) or (b) except with the agreement of each of the provinces.

Exception

(3) Subsection (2) does not apply in respect of regulations made under paragraph (1)(a) if they are substantially the same as regulations made under the Act of 1977, as it read immediately prior to April 1, 1984.

Consultation with provinces

(4) No regulation may be made under paragraph (1)(c) or (d) unless the Minister has first consulted with the ministers responsible for health care in the provinces. 1984, c. 6, s. 22.

Annual report by Minister

23. The Minister shall, as soon as possible after the termination of each fiscal year and in any event not later than December 31 of the next fiscal year, make a report respecting the administration and operation of this Act for that fiscal year, including all relevant information on the extent to which provincial health care insurance plans have satisfied the criteria, and the extent to which the provinces have satisfied the conditions, for payment under this Act and shall cause the report to be laid before each House of Parliament on any of the first fifteen days on which that House is sitting after the report is completed. 1984, c. 6, s. 23.

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